Considerations for the Legal Recognition of Advance Directives : A Comparative Analysis

BY

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DECLARATION

I, **SURAKSHA SHREEPAL** do hereby declare that, this dissertation entitled,

Considerations for the Legal Recognition of Advance Directives : A Comparative Analysis

(i) Is a result of my own original research and work except where indicated otherwise.

(ii) Has been thoroughly referenced acknowledging the various sources and authors mentioned in the dissertation.

(iii) Has not been previously submitted in part or in full for any other degree or to any other University.

SIGNATURE: S. Shreepal

DATE: 13th December 2019

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ABSTRACT

An advance directive[1] refers to a document drafted by a person in his[2] full senses and who foresees that due to some physical or mental disease, he may fall into a state where he will no longer be able to make rational decisions on his medical treatment or care[3]. Within this document, he purports to make requests or give orders to those who will be responsible for his medical care or treatment[4] when he is rendered unable to do so himself.

However, South African Law has no clear legal guidelines or any definite statutes or legislation regarding advance directives[5] except for the Health Professions Council of South Africa Guidelines[6] and the South African Medical Association Guidelines[7]. The National Health Act[8] does however to some extent mention and provide for the appointment of proxies and substitute healthcare decision makers which provides for an effective way for patients to appoint another to make treatment and consent decisions on their behalf when they can no longer do so themselves[9].

[1] Kindly note that the terms Advance Directive and Living Will are one and the same thing and will be used interchangeably throughout this dissertation.
[2] Kindly note that the terms "he" and "his" will be used throughout this dissertation. However, these aforementioned terms do not refer only to a male per say and includes a female person. Further, these aforementioned terms are not used to exclude other persons i.e. females are also applicable.
[3] H Oosthuizen '*Doctors Can Kill Active Euthanasia In South Africa'* (2003) 22 (3) *Medicine And Law* 554.
[4] Ibid.
[5] A Skeen "*Living Wills And Advance Directives In South African Law*' (2004) 23 (4) *Medicine And Law* 938.
[6] Health Professions Council Of South Africa, 'Guidelines For The Withholding And Withdrawing Of Treatment' *Booklet 7* (2008) Available at *www.hpcsa.co.za/Conduct?Ethics*Accessed on 17 May 2017 6.
[7] South African Medical Association 'Living Wills And Advance Directive' (2012) Available at *https://www.google.co.za/url?sa=t&source=web&rct=https://www.samedical.org/images/attacthments/guidelines-with-regard-to-living-wills-2012.pdf&ved=2ahUKEwiAtoadsMvaAhXlesAKHdXhAAwQFjAAegQIBxAB&usg=AOvVaw10crEiYuaNdq5k0123dqWsU* Accessed on 20 February 2017.
[8] The National Health Act 61 of 2003.
[9] D J Mcquiod-Mason 'Advance Directives And The National Health Act' (2006) 96 (12) 1236.

There is also no specific and direct case authority at common law to provide clarity[10]. The only case relating to Advance Directives and which was heard in a South African Court was the case of *Clarke NO v Hurst*[11] which influenced the introduction of the Health Professions Council of South Africa Guidelines[12] and the South African Medical Association Guidelines[13]. The only draft legislation in relation to advance directives in South Africa is the, South African Law Commission Report Project 86: 'Euthanasia and the Artificial Preservation of Life'[14] as well as the National Amendment Bill, 2018, (Private Member's Bill)[15].

The Constitution[16] is the supreme law of the land and the state has a duty to ensure that all rights are not violated or infringed against, at all costs[17]. However, Section 36 of the Constitution[18] provides for a General Limitation Clause which provides for all rights within the Bill of Rights to be limited in terms of general application and states that any limitation must however, be reasonable and justifiable made with good cause. The right to dignity[19], the right to life[20], the right to privacy[21] and the right to security and control over one's body[22] is of vital importance in relation to advance directives. These aforementioned rights affirm the rights of individuals to refuse treatment even

[10] L Jordaan '*The Legal Validity Of An Advance Refusal Of Medical Treatment In South African Law* (Part 1)' (2011) 44 (1) *De Jure* 36.
[11] *Clarke No v Hurst and Others* 1992 (4) SA 630 (D).
[12] See Note 5 above.
[13] See Note 6 above.
[14] South African Law Commission Report, Project 86: 'Euthanasia And The Artificial Preservation Of Life' (1998) Available from *https://www.google.co.za/url?sa=t&source=web&rct=j&url=http://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf&ved=2ahUKEwjm3Zjyq8vaAhViJMAKHayBDzcQFjAAegQIBhAB&usg=AOvVawOBjufojuBTBMIMbk5jJVVB*Accessed on 20 February 2017.
[15] GN 408 of GG 41789, 24/07/18; 4-5.
[16] The Constitution of The Republic of South Africa, 1996.
[17] D J McQuiod-Mason '*Stransham-Ford v Minister of Justice and Correctional Services and Others: Can Active Voluntary Euthanasia and Doctor-Assisted Suicide Be Legally Justified and Are They Consistent With The Biomedical Ethical Principles? Some Suggested Guidelines For Doctors To Consider*' (2015) 8 (2) SAJBL 35.
[18] The Constitution of The Republic of South Africa, 1996.
[19] Section 10 of the Constitution of The Republic of South Africa, 1996.
[20] Section 11 of the Constitution of The Republic of South Africa, 1996.
[21] Section 14 of the Constitution of The Republic of South Africa, 1996.
[22] Section 12 of the Constitution of The Republic of South Africa, 1996.

if it may result in their death[23]. Thus, this dissertation will argue and motivate that valid refusals of treatment or procedures contained in advance directives should be honoured and further given legal credence.

Notwithstanding the existence of draft legislation, advance directives has not been implemented and introduced in South Africa, hence advance directives are not legally binding documents[24]. The physician's liability also remains unclear if they comply with such directives without a court granting an order[25].

This dissertation seeks to explore the different types of advance directives and the position in South Africa. It also compares and contrasts the position to other like-minded jurisdictions. Namely, Canada and the United Kingdom (UK). Canada will be focused on largely as many provinces within Canada have implemented legislation regulating the use of advance directives and which gives legal recognition to said advance directives[26]. The UK will be discussed as numerous case authorities exist favouring the use of advance directives[27]. Important to note is that, the UK does not only have case authority which deals with advance directives and end of life decisions but also respects and honours valid refusals of treatment as long as they were made in accordance to the requirements of the relevant legislation[28].

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[23] See Note 16.35.
[24] See Note 4.943.
[25] Ibid.
[26] G Robertson '*Advance Directives*' (2006) Available at http://www.thecanadianencyclopedia.ca/en/m/article/advancedirectives/Accessed on 11 November 2017.
[27] Law Reform Report: *Bioethics: Advance Care Directives (2009)* Available at *https://www.google.co.za/url?sa=t&source=web&rct=j&url=http://www.lawreform.ie/_fileupload/reports/rbioethics.pdf&ved=2ahUKEwjytYmnodzeAhXLI8AKHZJKAe0QFjAAegQIBxAB&usg=AOvVawOtP_G8j4wzD2A_ngof1yrW* Accessed on 05 November 2018. 15.
[28] Ibid.

CHAPTER ONE

OVERVIEW OF THE DISSERTATION

"I believe that terminally ill people should be treated with the same compassion and fairness when it comes to their deaths. Dying people should have the right to choose how and when they leave mother earth"[29].

1.1. Background to the Topic

Advance directives or 'living wills' have been in existence for a long period of time and has been both a major debate and global concern. There has been a number of issues that have arisen over the years since the legal status of advance directives has not yet been clarified[30]. Such advance directives do not fall under the Wills Act[31] in South Africa nor are they recognised explicitly by any other statute[32].

In addition, case law is vague with regard to the legal position of advance directives as there is no direct authority at common law dealing with such except for the case of *Clarke*[33] which was heard in a South African Court[34]. The

[29] D Tutu '*Archbishop Desmond Tutu: When My Time Comes, I Want The Option Of An Assisted Death'* (2016) Available from *https://www.washingtonpost.com/opinions/global-opinions/archbishop-desmond-tutu-when-my-time-comes-i-want-the-option-of-an-assisted-death/2016/10/06/97c804f2-8a81-11e6-b24f-a7f89eb68887_story.html?utm_term=.b77013ac88f0* Accessed on 28 March 2018.
[30] See Note 4.938.
[31] Wills Act 7 of 1953.
[32] See Note 9.36.
[33] *Clarke* supra.
[34] See Note 9.37.

only case which mentioned advance directives was the case of *Clarke*[35], as aforementioned but the court in this case did not base its decision on the patient's instructions nor did it rule on the validity of the 'living will'[36]. Therefore, the current legal position of advance directives was left unclear and the position still remains vague even in the modern, democratic, Constitutional era[37].

One of the issues that often arise is, where a person has drafted an advance directive whilst being in a mentally competent state together with the required legal capacity to do so and the treating physician is now faced with such patient being terminally ill and is unsure of how to proceed legally[38]. The situation becomes more problematic where an individual is mentally ill, has no advance directive in place and cannot make a decision regarding their medical treatment[39]. Though this is catered for in the National Health Act[40], problems do occur both legally and ethically. Another issue arises where, the individual drafts a directive and then becomes mentally incompetent after the directive has been drafted and it is unclear whether the physician should proceed with upholding the directive in place or refusing to accept it[41]. Therefore, this dissertation seeks to illustrate the possible difficulties which may arise in the aforementioned situations if definite legislation is not implemented.

When physicians are faced with advance directives, both ethical and legal consequences automatically arise, more so in jurisdictions that do not afford these documents legal status. The Constitution[42] is the supreme law of the

[35] *Clarke* supra.
[36] See note 9.37.
[37] Ibid.36.
[38] See Note 9.34.
[39] Ibid.
[40] The National Health Act 61 of 2003.
[41] See Note9.34.
[42] The Constitution of The Republic of South Africa, 1996.

Republic and every individual is entitled to these rights contained in the Constitution. The right to life[43], the right to dignity[44], the right to security and control over one's body[45] and the right to privacy[46] are important in relation to advance directives and a physician is entitled to uphold such rights[47]. If the terminally ill patient has a family or spouse, the family or spouse's views are considered in the decision-making process[48].

In 1992, the South African Law Reform Commission made an effort to address the problem by introducing draft legislation relating to advance directives in South Africa entitled, The South African Law Commission Report Project 86: 'Euthanasia and the Artificial Preservation of Life'[49]. This draft legislation entitles medical practitioners to honour directives drafted by patients when they were mentally competent[50]. However, it has not yet been passed by Parliament and the physician's liability acting in accordance with a directive not authorised by a court order still remains uncertain under South African law[51] even though the Health Professions Council of South Africa Guidelines[52] and the South African Medical Association Guidelines[53] are in existence to provide guidance to medical practitioners.

In 2018, Ms Deidre Carter, who is a member of the Parliament in South Africa has introduced the National Health Amendment Bill (2018), *Private Members Bill*[54] though this Bill has not been passed by Parliament as yet and has not

[43] Section 11 of the Constitution of The Republic of South Africa, 1996.
[44] Section 10 of the Constitution of The Republic of South Africa, 1996.
[45] Section 12 of the Constitution of The Republic of South Africa, 1996.
[46] Section 14 of the Constitution of The Republic of South Africa, 1996.
[47] See Note 16.35.
[48] Ibid.
[49] See Note 13.
[50] See Note 9.37.
[51] Ibid.38.
[52] See Note 5.
[53] See Note 6.
[54] See Note 14.

been enacted to make said Bill legally binding. This draft bill has been introduced to curb the numerous problems that do arise when dealing with advance directives by providing legal recognition, legal certainty and legal enforceability to said directives and durable power of attorneys for healthcare[55].

1.2. Research question

This dissertation seeks to explore the concepts of advance directives by comparing and contrasting the current legal position in South Africa to the position of other like-minded jurisdictions such as Canada and the UK to portray the gaps existing within South African Law and forge a way forward towards legal recognition.

The main reason the jurisdiction of Canada was chosen is because five Canadian provinces currently have legislation and laws in place which authorise the use and implementation of advance directives[56]. Such provinces are Nova Scotia, Quebec, Manitoba, Newfoundland and Ontario[57].

The jurisdiction of the UK was further chosen due to the fact that legislation was implemented regulating the use of advance directives[58]. As aforementioned, the UK does not only have case authority which deals with advance directives and end of life decisions but also respects and honours valid

[55] Ibid.4.
[56] See Note 24.
[57] Ibid.
[58] See Note 25.

refusals of treatment as long as they were made in accordance to the requirements of the relevant legislation[59].

Lastly, this dissertation will portray how the non-recognition of advance directives impacts on an individual's rights. More specifically, the terminally ill patient's rights. Such rights are the right to dignity[60], the right to life[61], the right to privacy[62] and the right to security and control over one's body[63].

1.2.1. Questions to be addressed within this dissertation are as follows:

- What are advanced directives?
- What is the current legal position in South Africa in relation to advance directives?
- What is the common law position?
- What are the ethical views of such advance directives being enacted and respected?
- How does the Constitution play a role in relation to advance directives?
- What are the physician's views, patient's views and family members views of said patient when considering whether to uphold an advance directive or not?
- What is the position when a patient has an advance directive, is mentally incompetent and terminally ill? What if said patient does not have an advance directive and the similar circumstances follow?

[59] Ibid.
[60] Section 10 of the Constitution of The Republic of South Africa, 1996.
[61] Section 11 of the Constitution of The Republic of South Africa, 1996
[62] Section 14 of the Constitution of The Republic of South Africa, 1996
[63] Section 12 of the Constitution of The Republic of South Africa, 1996

- Are there any guidelines to assist physicians?
- What is the law regarding advance directives internationally. More, specifically, in Canada and the United Kingdom?
- How must South African Law be improved to accommodate the use of advance directives lawfully?

1.3. Overview of chapters

Chapter one shall provide an overview of the dissertation at hand. It will comprise of a brief background to the topic, the research question, an overview of the chapters, definitions and the research methodology.

Chapter two shall focus largely on the current legal position of advance directives in South Africa by looking at the common law position, the constitutional framework and the various policies and guidelines developed to assist physicians and individuals in relation to advance directives. Most importantly, the South African Law Commission Report Project 86[64] and the National Health Amendment Bill (2018)[65] will be analysed and discussed in detail. An analysis of the four biomedical principles will also be discussed. Lastly, the ethical views towards advance directives will be mentioned.

Chapter three shall focus on the current legal position of advance directives in Canada. The common law position together with case law will be discussed briefly. Emphasis is placed on the Canadian Charter of Rights and Freedoms[66] by looking at the rights central to discussion. Lastly, various Acts, Policies and Guidelines will be explored and discussed. Within this chapter, this dissertation will portray the reasons as to why the jurisdiction of Canada was chosen as a

[64] See Note 11.
[65] See Note 14.
[66] *Canadian Charter Of Rights And Freedoms*, Part 1 of The Constitution Act, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

comparative jurisdiction as opposed to other jurisdictions around the continent.

Chapter four shall focus broadly on the current legal position of advance directives in the United Kingdom. More specifically, the legal position with regards to advance directives will focus on the countries of England, Wales and Scotland. Case authority will also be central to discussion. The limitation of a patient's autonomy and whether a physician is forced to comply with the advance directives made by a patient will be discussed.

Chapter five shall focus on the conclusion and recommendations to improve the legal situation regarding advance directives in South Africa. The recommendations shall include further requirements to be added to the South African Law Reform Commission to provide clarity and legal certainty for both medical professionals and patients for the future.

1.4. Definitions

1.4.1. Terminal illness is defined as an incurable condition caused by an injury or disease from which there is no reasonable prospects of either a temporary or permanent recovery regardless of the application of extraordinary life-sustaining treatment which would only act to postpone the moment of death[67].

1.4.2. Extraordinary life - sustaining treatment is defined as any medical procedure, treatment or measure when administered to terminally ill

[67] T K Leng& S L Huey '*Advance Medical Directives In Singapore'* 5 (1) *Medical Law Review* 64.

patients which will only serve to prolong the process of dying[68]. Examples of such extraordinary life-sustaining treatment are ventilators to take over natural breathing or cardiopulmonary resuscitation to keep the heart beating where such treatment would only serve to postpone the moment of death which in inevitable[69].

1.4.3. Permanent vegetative state is defined as a "neurological condition where a subject retains the capacity to maintain the vegetative part of neurological function but has no cognitive function"[70]. In other words, the body is functioning entirely in terms of its internal controls and maintains certain biological functions such as digestive activity but there is "no behavioural evidence of either self-awareness or awareness of the surroundings"[71].

1.4.4. Advance Directives/Living Wills can be defined as 'instructional directives' whereby an individual sets out what type/s of treatment he/she wishes to receive or alternatively, to refuse in the event of them becoming incompetent[72].

1.4.5. Proxy-Directives refer to a directive in which the maker appoints another individual of their choice to make both medical and treatment decisions on his/her behalf[73].

[68] Ibid.73.
[69] Ibid.
[70] See note 9.36.
[71] Ibid.
[72] See Note 2.554.
[73] See note 9.34.

1.4.6. Power of Attorney is often used interchangeably as Proxy-directives because it means appointing another to make medical and treatment decisions on the maker's behalf[74].

1.4.7. Enduring Power of Attorney is defined as an individual appointing another to handle his/her affairs as well as to make decisions on their behalf. An enduring power of attorney carries on even after the said individual becomes incompetent and or mentally incapable of handling his/her own affairs[75].

1.5. Research Methodology

This dissertation is based purely on literature review and desktop research. It requires no physical collection of data by means of interviews or surveys. The main sources of information is derived from academic journal articles and publications, internet sources, textbooks, electronic books and lastly, various acts, statutes and codes of conduct together with policies or guidelines.

1.6. Conclusion

This chapter has focused on a brief overview of what the dissertation at hand will entail. It has focused on the background of the chosen topic and the problems experienced by South Africa not having definite legislation in place regardless of the guidelines which were introduced. This chapter also contains

[74] Ibid.
[75] Gauteng Law Council – '*Regsraad – Lekgotla'* Available at *http://www.gautenglaw.co.za/content/index.cfm?navID=7&itemID=73* Accessed on 09 January 2019.

a research question which elaborates on the purpose and aims of the dissertation and what it seeks to achieve. Lastly, it gives an overview of what each individual chapter will focus on going forward.

CHAPTER 2

THE CURRENT LEGAL POSITION OF ADVANCE DIRECTIVES IN SOUTH AFRICA

2.1. Introduction

Currently, South African Law has no definite legislation regarding advance directives[76]. Though, South African Law has a limited number of Guidelines and Policies which deal with advance directives[77]. Such a lack of definite legislation regarding advance directives can result in numerous problems if not regulated[78].

Some problems include the issues of whether medical practitioners or medical staff are expected to comply with the living will on moral and ethical grounds and whether the cessation of life supporting treatment is illegal[79]. There is also a state of uncertainty whether a medical practitioner complying with a living will would be subject to criminal or civil actions and lastly, there is no criminal sanction for the abuse of a living will involving destruction, concealment or fraud[80].

The case of *Clarke*[81] concerned a medical practitioner who was a member of a Voluntary Euthanasia Society and who had signed a living will[82]. He then suffered a sudden drop in blood pressure and went into cardiac arrest later,

[76] See Note 4.940.
[77] Ibid.
[78] Ibid.
[79] Ibid.941.
[80] Ibid.
[81] *Clarke* supra
[82] S A Strauss '*The Right To Die Or Passive Euthanasia: Two Important Decisions, One American And The Other South African'* 1993 6 (2*) South African Journal Of Criminal Justice* 201.

lapsing into a permanent vegetative state[83]. He was unable to take food hence, he was artificially fed through a nasogastric tube[84]. His wife applied to court to withdraw and discontinue the nasogastric feeding despite the fact that her decision may hasten the death of the patient[85]. The court in this case granted the order and found that the continued artificial feeding would not serve the purpose of human life and allowed the patient's wife to order its withdrawal without being exposed to any legal sanctions[86].

A point to be noted about this specific case is that it was the first case within South Africa which dealt with living wills even though the court did not directly address the question about the patient's living will at the time[87]. The judge in this case who was Thirion J, was not prepared to give absolute recognition to an advance directive[88]. The patient's curator-ad-litem argued, "An adult of full legal competence has, while of sound mind, an absolute right to the security and integrity of his body. In the exercise of that right he is entitled to refuse to undergo medical treatment, irrespective of whether such refusal would lead to his death…where, as in the present case, such a person while he is of sound mind, has directed that should he lapse into a persistent vegetative state with no prospect of recovery, he should be allowed to die and that he should not be kept alive by artificial means, then if he does lapse into such a state, there is no reason why a curator appointed to his person should not have the power to give effect to his direction"[89].

In essence, even though the patients curator-ad-litem argued that the patients living will be recognized as he was of sound mind when he drafted same as

[83] Ibid. 202.
[84] Ibid.
[85] Ibid.
[86] Ibid.204.
[87] See note 4.938.
[88] See note 80.203.
[89] Ibid.203-204.

aforementioned, the judge refused to uphold the argument and was not prepared to give full recognition to modern medical views on patient autonomy[90].

The judge held further that the discontinuance of an artificial feeding would not be the legal cause of the death[91]. As according to the legal convictions of the community, it would not be seen as wrongful or unlawful to discontinue the artificial feeding which was previously administered just to keep him 'alive'[92]. The court ruled that it would be in the patient's interest to permit him to die because just as a living person has an interest in the disposal of his/her body, his wishes that were indeed previously expressed when he was competent should be given effect thereto[93].

2.2. Definition of Advance Directives

When a person is no longer capable to make decisions on his treatment and care, medical practitioners are then dependent on previously obtained consent or orders from authorized persons or on their own judgment in consideration of the ethical code to which they are bound[94].

An advance directive usually in the form of a 'living will', is a document drafted by a person in his full senses and who foresees that, due to some physical or mental disease, he may fall into a state where he will no longer be able to

[90] See Note 4.938.
[91] See note 80.206.
[92] Ibid.
[93] See Note 4.938.
[94] See note 2.554.

make rational decisions on his medical treatment or care[95] for himself and by himself.

In this document, he attempts to make requests or give orders to those who will be responsible for his medical care or treatment[96]. Thus, the objective of an advance directive or living will is to provide guidelines or a clear statement to physicians of what is to be done or what is not to be done to patients' when a patient can no longer do that anymore and further, to indemnify practitioners against liability in such circumstances[97].

An advance directive takes two forms. Namely, an instructional directive or 'living will' and a proxy directive. A proxy directive refers to a directive in which the maker appoints an individual of their choice to act as a medical care agent to make medical and treatment decisions on his or her behalf[98]. Although, a person can complete either an instructional or proxy directive, the two can also be combined[99].

In South African Law, neither living wills nor enduring powers of attorney have been explicitly recognised by statute except for the National Health Act[100] which now provides for patients to appoint proxies to make decisions on their behalf[101]. Prof McQuiod - Mason argues that, living wills should be recognised at common law due to the fact that they reflect the current wishes of the patient[102].

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[95] Ibid.
[96] Ibid.
[97] Ibid.
[98] B Sneiderman& D J McQuiod-Mason '*Decision-Making At The End Of Life: The Termination Of Life-Prolonging Treatment, Euthanasia (Mercy-Killing), And Assisted Suicide In Canada And South Africa'* (2000) 33 (2) *Comparative And International Law Journal Of South Africa* 196.
[99] Ibid.
[100] The National Health Act 61 of 2003.
[101] See Note 9.
[102] Ibid.

The main reason why powers of attorney cannot be recognised at common law solely is because such powers of attorney become invalid when the patient becomes mentally incompetent[103]. In order for a power of attorney to be deemed valid, the maker must have the necessary contractual capacity to act. If he does not have the necessary contractual capacity to act himself then he cannot authorise another to act on his behalf[104]. Therefore, a person who cannot understand the importance, nature and consequences of granting a power of attorney cannot validly execute said power of attorney as it would automatically lapse once the maker loses the legal capacity to act[105].

If a valid power of attorney is in existence and the maker has authorised another to act on his/her behalf but the maker loses the legal capacity to act or is rendered mentally incompetent then, the power of attorney becomes void[106]. If the authorised person continues to act on the makers behalf and uphold the power of attorney which is now deemed void, he is exposing himself to personal liability for any losses suffered by a third party as a result of transactions which arise from the void power of attorney[107].

Enduring powers of attorney are valid and binding in countries such as the United Kingdom, Canada and Australia. This type of power of attorney remains in force regardless if the maker becomes mentally incompetent or lacks the legal capacity to act[108]. All that is required is that the maker whilst still mentally competent must execute an enduring power of attorney stating that it is to remain valid regardless of the lack of capacity which may arise in the future[109].

[103] Ibid.
[104] See note 8.1236.
[105] Ibid.
[106] Ibid.
[107] Ibid.
[108] Ibid.
[109] See Note 74.

However, South African Law does not accept enduring powers of attorney though the South African Law Reform Commission has made recommendations in its report entitled, "Assisted Decision-Making :Adults With Impaired Decision-Making Capacity[110]" which mentioned enduring powers of attorney and which was included in a draft bill. Despite the recommendations which were included in a draft bill, the matter has never gone forward and uncertainty still remains within our law.

2.3. Advantages of Advance Directives

- The main advantage of having a directive in place is that, individuals' can be assured that their prior wishes, values or instructions will be honoured and respected in the event of them becoming incompetent and cannot make treatment decisions[111].
- Directives ease the burden and pressure placed upon family members in deciding whether they should consent to administering treatment or either withdrawing such medical treatment on terminally ill patients with no signs of recovery[112].
- Lastly, healthcare practitioners are relieved of the psychological distress by not knowing what the patient would have consented or not consented to in the current situation[113]. They feel more confident by either administering or not administering medical treatment to the

[110] Assisted Decision-Making: Adults With Impaired Decision-Making Capacity (2004) Available at http://docplayer.net/8569280-South-african-law-commision-assisted-decision-making-adults-with-impaired-decision-making-capacity.html Accessed on 22 February 2019.
[111] A Conroy '*Patient Autonomy And the Realities Of Substitute Decision-Making: Reassessing Advance Directives Legislation In Common Law Canada'* (2013) 34 (36) *Windsor Review of Legal And Social Issues* 41.
[112] Ibid.
[113] Ibid.

terminally ill patient and they are aware they are respecting such patient's prior wishes[114].

2.4. Disadvantages of Advance Directives

- A criticism against the implementation of directives is that the thoughts and views of a competent patient are different to the time when they are in a persistent vegetative state and rendered totally incompetent[115]. Had they been able to express their wishes when they were in such a state might be different to the decision taken when they were able and competent[116].
- It is argued that, it is difficult for an individual drafting the directive to predict all the situations that could occur[117]. Therefore, directives could lead to inappropriate decisions being taken that the individual did not foresee[118].
- Lastly, the concern is that people tend to easily forget to change or update their directive and in which case, medical treatment may be provided to a terminally ill patient who would have otherwise rejected such treatment[119].

By comparing the advantages of directives to the disadvantages of directives being implemented, one can argue that the advantages outweigh the disadvantages. Revocation of directives is provided for in the event of individuals having a change of mind so they can easily revoke. By having a

[114] Ibid.
[115] Ibid.42.
[116] Ibid.
[117] Ibid.
[118] Ibid.
[119] Ibid.

directive in place, both the treating physician and family members of the terminally ill patient have a sense of direction and can feel assured that they are acting in accordance with their wishes[120].

2.5. Difference between euthanasia and advance directives

Euthanasia refers to situations where doctors hasten the death of a patient by prescribing or administering a particular medicine, lethal drug or agent or by the withholding or withdrawing of medical treatment[121]. Advance directives on the other hand, do not seek to hasten the natural end of death and is different from euthanasia where deliberate intervention indeed hastens the death of a patient[122].

With advance directives, the underlying disease or trauma takes its course and leads to the patient's death and is not a direct act by the health worker[123] although it has been argued that the act of 'unplugging' or discontinuing treatment (life-sustaining or otherwise) acts as the *novus actus intervinens*. In the case of *Clarke*[124], the Attorney-General of Natal opposed the application brought by the patients wife on the basis that, the discontinuance of the artificial feeding would be the cause of the death as it would hasten the patient's death and that, the wife could be liable of unlawfully and intentionally killing the patient under the law[125]resulting in the crime of murder. However, the court ruled that, the discontinuance of an artificial

[120] Ibid.41.
[121] See Note 16.36.
[122] R K Carr '*Advance Directives-Living Will'* (2010) 2, Available at http://mcsadewcom.blogspot.com/2010/03/advance-directives-living-will.htmlAccessed on 04 February 2017.
[123] Ibid.
[124]*Clarke* supra.
[125] See Note 80.202.

feeding would not be the legal cause of the death of the patient[126]. As previously mentioned, according to the legal convictions of the community, it would not be seen as wrongful or unlawful to discontinue the artificial feeding which was previously administered just to keep him 'alive'[127]. The court then ruled that it would be in the patient's interest to permit him to die.

In conclusion, where advance directives are implemented, a person has the capacity to live to the full extent of his or her life without medical intervention and because there is no deliberate intention to intervene in ending life, advance directives cannot be seen as a rejection of the sanctity of life[128].

2.6. The Constitutional Legal Framework

The South African Constitution contains a Bill Of Rights (Chapter 2)[129] which sets out all of the fundamental rights and freedoms an individual in South Africa is entitled to[130]. The Bill of Rights is the cornerstone of democracy in South Africa[131].

The Constitution is also the supreme law of the Republic and any law or conduct that is deemed to be inconsistent with it is regarded as being invalid[132]. In addition, all the obligations imposed by the constitution have to be fulfilled[133]. Section 1(a) of the Constitution states that, the Republic of South Africa is a democratic state which is founded on the values of human dignity, the achievement of equality and the advancement of human rights and

[126] Ibid.
[127] Ibid.
[128] See Note 103.
[129] The Constitution Of the Republic Of South Africa, 1996, Bill Of Rights, Chapter 2.
[130] See Note 16.35.
[131] Ibid.
[132] Ibid.
[133] Ibid.

freedoms[134]. Rights provided for in the Constitution cannot be reduced unless it is reasonable and justifiable in terms of Section 36 of the Constitution[135]. The following rights as contained in the Constitution and which is applicable to advance directives will be discussed below.

2.6.1. The Right to life

Section 11 of the Bill of Rights states:

"Everyone has the right to life"[136].

In relation to advance directives and the right to refuse medical treatment (which is specifically provided for in the South African Medical Association [SAMA] Guidelines[137]), this right to life entails the principle of 'quality of life"[138]. The quality of life is concerned with the assessment of the worthwhileness of the patient's life and states that, the right to life must be a life worth living[139]. It rejects the argument that there is something good in life itself[140].

The case of *Makwanyane[141]* stated that, the right to life must be a life worth living and is linked to the right to dignity therefore, courts should not be influenced by public opinion but by constitutional values namely, dignity[142]. The court held that, "the right to life is, in one sense, antecedent to all other rights in the Constitution. Without life in the sense of existence, it would not

[134] Ibid.
[135] Ibid.
[136]The Constitution Of the Republic Of South Africa, 1996, Bill Of Rights, Section 11.
[137] See Note 6.
[138] See Note 9.46.
[139] Ibid.
[140] Ibid.
[141]*S v Makwanyane* 1995 (3) SA 391 (CC).
[142] D J McQuiod-Mason '*Doctor-Assisted Suicide: What Is The Present Legal Position In South Africa*?' (2015) 105.

be possible to exercise rights or to be the bearer of them". The court held further that, the "right to life was included in the Constitution not simply to enshrine the right to existence but the right to human life which is the right to live as a human being"[143]. The court went on further to state that the right to life incorporates the right to dignity and that these rights are entwined[144]. It was stated that, "the right to life is more than existence, it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished. Without life there is no dignity"[145].

Therefore, as seen from the Courts judgment quoted above, the right to life is linked very closely to the right of dignity[146]. Further, the right to life entails a life worth living and is a right to be treated as a human being as aforementioned by the court in the case of *Makwanyane*[147]. By refusing to honour and uphold an individual's advance directive, an individual's constitutional right to life is been infringed upon. Hence, individual's draft an advance directive in the hope that should such situations arise where they are rendered unable to make treatment decisions for themselves, their advance directives would indicate their preferences, choices and treatment decisions to their treating physicians being in accordance to that of their wishes[148]. When an individual is terminally ill, they are not aware of their surroundings or senses per say as their quality of life is diminished. They are in tremendous pain and suffering which does not amount to a life worth living[149].

[143] *S v Makwanyane* 1995 (3) SA 391 (CC) at Par. (326), 178.
[144] Ibid.
[145] Ibid.
[146] See Note 123.105.
[147] *Makwanyane supra.*
[148] See note 3 above. 555.
[149] See Note 16.37.

In the case of *Clarke*[150], the court ordered the withdrawal of the artificial feeding because it reasoned that said artificial feeding would not serve the purpose of supporting human life[151]. This aforementioned statement made by the judge supports the right to life.

Therefore, advance directives drafted by competent people should be respected in the event of them becoming terminally ill and being rendered incompetent to make treatment decisions for themselves as they are unable to live a life that is worth living[152].

2.6.2. The Right to Dignity

Section 10 of the Bill of Rights states:

"Everyone has inherent dignity and the right to have their dignity respected and protected"[153].

This right to dignity is linked closely to the right to life as it protects the right to life but not a life where an individual merely exists and results further in undermining an individual's dignity[154]. When a patient is terminally ill, they are in extreme pain and suffering even though they are rendered incompetent[155]. It can be argued that there is no 'dignity' if an individual is forced to be kept alive against their wishes.

Dworkin makes an important differentiation between 'critical interests' and 'experiential interests' of an individual. Critical interests refer to a person's

[150] *Clarke* supra.
[151] See Note 16.37.
[152] See note 3 above. 555.
[153] The Constitution Of the Republic Of South Africa, 1996, Bill Of Rights, Section 10.
[154] See Note 16.37.
[155] Ibid.

sense of identity whilst, experiential interests can be defined as the daily activities of an individual such as playing sport, enjoying a meal or reading a novel[156]. The main aim of drafting an advance directive is mainly to preserve their capacity to control their life as well as their dignity[157]. Therefore, as argued by Dworkin, "advance directives should be obeyed because it presents a person's critical interests, namely, how to live and how to die"[158]. The lack of control over one's body results in the loss of dignity thus infringing their right as contained in the constitution[159].

2.6.3. The Right to Freedom and Security of the Person

Section 12 (1) of the Bill of Rights states:

"Everyone has the right to freedom and security of the person, which includes the right-

(e) not to be treated or punished in a cruel, inhuman or degrading way[160]".

Section 12 (2) of the Bill of Rights states:

"Everyone has the right to bodily and psychological integrity, which includes the right-

(a) To make decisions concerning reproduction

(b) To security in and control over their body and;

[156] L Jordaan, '*The Legal Validity of An Advance Refusal of Medical Treatment In South African Law (Part 1)' (*2011) 42.
[157] Ibid.43.
[158] Ibid.
[159] Ibid.
[160] The Constitution Of the Republic Of South Africa, 1996, Bill Of Rights, Section 12 (1) (d)(e).

(c) Not to be subjected to medical or scientific experiments without their informed consent[161]".

A patient always retains the right to decide what treatment will or will not be received even if that decision is contrary to medical advice[162]. The right for patients' to refuse treatment is a constitutional right guaranteed to such patients' found in Section 12 of the Constitution[163]. The above-mentioned right is based on the right to information provided for in terms of Section 32[164] of the Constitution and the medical principle of informed consent which will be discussed shortly.

It is clear that the right to bodily integrity and the right to dignity provide the basis for a patient to refuse medical treatment in accordance with their own wishes despite the fact that it may lead to their death[165]. Hence, it can be argued that the right to Freedom and Security of the Person advocates for advance directives.

2.6.4. Right to privacy

Section 14 of the Bill of Rights states: *"Everyone has the right to privacy, which includes the right not to have-*

(a) Their person or home searched;

(b) Their property searched;

(c) Their possessions seized; or

[161] The Constitution Of the Republic Of South Africa, 1996, Bill Of Rights, Section 12 (2) (a)(b)(c).
[162] See note 103.2.
[163] Ibid.
[164] Section 32 reads, *"(1) Everyone has the right of access to- (a) any information held by the state: and (b) any information that is held by another person and that is required for the exercise of protection of any rights".*
[165] See note 146.42.

(d) The privacy of their communications infringed"[166].

The right to dignity also plays a vital role to the right of privacy in the Constitution[167]. This right guarantees the individual the freedom to make specific private choices without the state interfering[168]. Such choices include choices about how to lead their own life as well as choices refusing medical treatment which may be contained in an advance directive[169].

2.7. Principle of Informed Consent

Informed consent means that, patients must be given sufficient information in a way that they can understand in order to enable them to exercise their right to make informed decisions about their healthcare[170]. The concept of 'informed consent' was first introduced in the case of *Stoffberg v Elliot*[171] in which the court held that informed consent is necessary and vital in that it needs to be obtained before making decisions for the patient[172].

In the case of *Castell v De Greef*[173], the court held that legally for informed consent the patient must have:

a. "Knowledge of the nature or extent of the harm or risk;
b. Appreciated and understood the nature of the harm or risk;
c. Consented to the harm or assumed the risk; and

[166] The Constitution Of the Republic Of South Africa, 1996, Bill Of Rights, Section 14(a)-(d).
[167] See Note 9.43.
[168] Ibid.
[169] Ibid.
[170] D J McQuiod-Mason '*Michael Jackson And The Limits Of Patient Autonomy*' (2015) 5 (1) *SAJBL* 11-12.
[171] *Stoffberg v Elliot* 1923 CPD 148.
[172] See Note 142.11.
[173] *Castell v De Greef* (1994) 4 SA 408 (C).

d. The consent must have been comprehensive (i.e. extended to the entire transaction, inclusive of its consequences). The court held further that, patients must be informed of all 'material risks' in order to give proper informed consent. A risk is material if:

(i) A reasonable person in the position of the patient, if warned of the risk, would attach significance to it; and

(ii) The health care practitioner should reasonably be aware that the patient, if warned of the risk, would attach significance to it"[174].

Thus, informed decisions mean that the patient is given full information regarding the nature, risks and benefits of the proposed medical treatment or procedure before consenting to it[175]. They must be given choices regarding such treatment or procedures that they can choose from with the full knowledge of the consequences that may arise from such decisions[176]. In addition, the National Health Act[177], states that patients must be provided with the range of diagnostic procedures and treatment options available together with the benefits, risks and consequences of such options[178].

Advance directives are therefore, the exercising of this right prior to the occurrence of the anticipated condition[179]. The doctrine of informed consent recognises an individual's autonomy to make decisions regarding whether or not they wish to receive or reject medical treatment[180]. Should they wish to undergo medical treatment, their wish should be respected. Likewise, should they wish to reject same, their wish should still be respected even if it may

[174] *Castell* supra at Par.426F-H.
[175] See note 142.11-12.
[176] Ibid.
[177] The National Health Act 61 of 2003.
[178] The National Health Act 61 of 2003; Section 6(1) (a)-(d).
[179] See Note 103.2.
[180] See note 146.35.

result in their death[181]. However, for the refusal of treatment to be of legal force, the patient must have had the capacity to refuse same as well as have the necessary knowledge regarding the nature and effect of such refusal[182]. Thus, it can be argued that the doctrine of informed consent advocates for the use and implementation of advance directives provided that the patient understands the nature, risks and consequences involved before consenting or rejecting medical treatment[183].

2.8. Legislation and Policies regulating Advance Directives

The following section hereunder will list some of the policies and guidelines dealing with advance directives. Important to note is that this list is not exhaustive.

2.8.1. The National Health Act[184]

The National Health Act[185] provides "grounds for arguing that advance directives in the form of enduring powers of attorney must be honoured by health care professionals"[186]. It further provides a way for patients who may mandate a person in writing to consent to a health service on their behalf when they cannot do so themselves[187]. Therefore, the National Health Act[188] provides an effective way for patients who may become mentally incompetent during a health service, to appoint proxies to make decisions on their behalf[189]. What is required is that the mandate be in writing although it is usually

[181] Ibid.
[182] Ibid.
[183] Ibid.36.
[184] The National Health Act 61 of 2003.
[185] The National Health Act 61 of 2003.
[186] See note 146.39.
[187] See Note 8.1236.
[188] The National Health Act 61 of 2003.
[189] Ibid.

advisable that the mandate be dated and signed by the patient as well as two witnesses[190]. It is usually recommended that in addition to implementing the living will, a proxy be appointed[191] as the proxy assists in the decision-making process based upon the patients previously known values as expressed in the living will[192] which was drafted at the time the patient was competent.

2.8.2. The South African Law Reform Commission Report

The draft legislation relating to advance directives in South Africa is the, South African Law Commission Report Project 86: 'Euthanasia and the Artificial Preservation of Life'[193]. This report was recommended in November 1998 but has not yet been passed by Parliament.

2.8.2.1. Section 6 of the proposed legislation is discussed as follows:

This section states that every person whom is of 18 years of age or older and of sound mind may, proceed with drafting an advance directive stating that they refuse further medical treatment in the event of them becoming incompetent and unable to communicate their wishes accordingly[194]. This section goes on further to state that the makers of advance directives can also appoint individuals/agents by way of written power of attorneys to make treatment decisions for them in the event of them becoming terminally ill and incompetent and that said power of attorneys will remain in force and take effect if they indeed become incompetent[195]. Lastly, this section states that where an individual is under guardianship or where a curator-ad-litem is

[190] Ibid.
[191] See Note 103.3.
[192] Ibid.
[193] See Note 11.
[194] See Note 11. Section 6 (1).
[195] See Note 11. Section 6(2).

appointed and said individual becomes terminally ill with no further instructions regarding their medical treatment options/decisions then, the decision will lie with that guardian or curator in the absence of court orders[196].

2.8.2.2. Section 7 of the proposed legislation is discussed as follows:

This section states that, no medical practitioners are entitled to honour advance directives unless they are first satisfied that the patient is suffering from a terminal illness[197], is unable to communicate their wishes or preferences[198] and has been confirmed by at least one other independent practitioner that said patient is indeed suffering from a terminal illness[199].This section goes on to state further that, the practitioner must ensure the authenticity of the advance directive[200] and must inform the patients interested family of his/her findings which should also be recorded in writing[201]. Lastly, this section states that, advance directives refusing medical treatment shall not be regarded as being invalid and unlawful even though it may hasten the death of the patient[202].

2.8.2.3. Section 8 of the proposed legislation is discussed as follows:

This section discusses the position of medical practitioners in the absence of advance directives. It states that, medical practitioners responsible for the patient who is terminally ill, has ascertained a professional opinion from an independent practitioner who has examined such patient and who has confirmed in writing that said patient is terminally ill may grant written authorisation for the cessation of further life-sustaining treatment and the

[196] See Note 11. Section 6 (4).
[197] See Note 11. Section 7 (1).
[198] Ibid.
[199] See Note 11. Section 7 (3).
[200] See Note 11. Section 7 (4).
[201] See Note 11. Section 7 (5).
[202] See Note 11. Section 7 (8).

administering of palliative care only in the absence of an advance directive or court order[203]. However, the medical practitioner may not act as such if the wishes of the patient's family are contrary unless a court order is in place authorising the practitioner to act as such[204].

Thus, to summarize the above, the commission authorizes health care practitioners to respect and honour advance directives prepared by a patient who was mentally competent at the time of drafting it regardless if it is in the form of a living will or a medical power of attorney authorizing another exists[205]. All that is required is that any person above the age of eighteen may make the directive by signing either the living will directing the withholding or withdrawing of medical treatment where a terminal illness is present or a power of attorney appointing another to make medical decisions in the event of the patient becoming terminally ill or incompetent[206].

As mentioned, the South African Law Reform Commission Report has been proposed in 1998 and has since been in the hands of the Minister of Health who has not taken this matter forward despite having the authority to instruct Parliament to enact same[207].

2.8.3. The National Health Amendment Bill (2018), *Private Members Bill*

This Bill if implemented will provide for the legal recognition, legal certainty and legal enforceability of advance directives in the form of living wills and durable powers of attorney[208]. As stated by Ms Deidre Carter, "the draft bill

[203] See Note 11. Section 8 (1).
[204] See Note 11. Section 8 (2).
[205] See Note 9.38.
[206] Ibid.
[207] See note 146.38.
[208] See Note 14.5.

will give legal protection and clarity to patients and medical practitioners about their rights and for patients wishes to be carried out, as it is their constitutional right"[209].

Ms Carter goes on to further state that numerous disputes, bitter fights, guilt, confusion and emotional trauma often arises amongst family members who disagree with the course of action for a dying family member despite the existence of a living will been in place[210]. Hence, with the Bill[211] been implemented, the solution to this problem would be to legally recognise the living will[212]. If the medical practitioner and family are guided by a legal instruction that was given, medical intervention can be stopped and a natural death can occur sooner[213].

The Draft Bill will also set out the purpose, scope and format for advance directives as well as how disputes could be resolved if they ever do arise[214]. Further, this Bill will clarify whether someone acting upon the wishes of a person contained in the advance directive will be immune from both civil and criminal immunity[215].

Important to note is the fact that this draft bill imitates the South African Law Reform Commission Report but differs in that it advocates for the legal recognition of advance directives.

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[209] U Ho '*A Living Will: MP Deidre Carter Campaigns To Make End-Of-Life Decisions Legally Enforceable'* (2018) Available at *https://www.dailymaverick.co.za/article/2018-08-24-mp-deidre-carter-campaigns-to-make-end-of-life-decisions-legally-enforceable/* Accessed on 10 January 2019.
[210] Ibid.
[211] See Note 11.
[212] See Note 174.
[213] Ibid.
[214] Ibid.
[215] Ibid.

2.8.4. South African Medical Association Guidelines

The South African Medical Association (SAMA)[216] published guidelines in 2012 that deals with living wills or advance directives. These set of guidelines have been published to assist healthcare practitioners when faced with an advance directive[217]. It states that all patients have a right to refuse treatment[218]. In addition, any person may refuse to accept medical treatment even if such refusal results in irreversible harm or death unless the prescribed treatment is sanctioned by law[219].

The guidelines further state that an advance directive shall be considered as the patients expressed wish in the absence of contrary evidence[220]. However, it is the patient's responsibility to ensure that their directive is updated continuously to reflect their current wishes[221]. It is advisable that patients discuss specific terms in the advance directive with their medical practitioner so no ambiguity or uncertainty arises[222]. It is also advisable that patients ensure their family or spouses or those persons who may be asked to comply with the provisions are aware of the existence of their advance directive so that it can be easily located if the need arises[223]. It can be argued that this aforementioned paragraph from the guidelines could be seen as clarifying the legal position for practitioners however, because there is no formal legal recognition, problems may and do arise for medical professionals.

[216] See Note 6.
[217] Ibid. 1.
[218] Ibid. (Section 2) 1.
[219] Ibid.1.
[220] Ibid (Section 3) 1.
[221] Ibid (Section 3) 2.
[222] Ibid.
[223] Ibid (Section 5) 2.

Most times, patients assume that if they end up terminally ill and they have an advance directive in place then it will automatically apply[224]. However, the situation is different in a medical reality. Depending on the language and wording used to draft the directive, it can either make medical matters easier or more difficult and complicated[225]. If the directive is drafted in a specific manner whereby it only mentions a certain set of circumstances to which the directive would apply and a whole different, entire situation arises then the directive would not apply as it would be viewed as being against the patient's wishes[226]. To contrast, if the directive is drafted in 'general' to cover almost every situation then it may be viewed as being vague because the medical practitioner would not be provided with a definitive direction as to which course to proceed with[227].

Ultimately, medical practitioners rely on their professional judgments in arriving at a decision[228]. They are also not obliged to uphold and follow an advance directive merely because it is in place if they have conscientious objections in withholding or withdrawing treatment[229]. A conscientious objection is defined as the refusal to perform a role or a responsibility based solely on personal beliefs[230]. With regards to healthcare, this term can be defined as practitioners not providing or refusing to provide certain treatments to their patients due to reasons of morality or conscience which can bring about harmful effects to the patient's healthcare[231].

[224] See note 9.35.
[225] Ibid.
[226] See note 6. (Section 5) 2.
[227] Ibid.
[228] Ibid.
[229] Ibid. (Section 7) 2.
[230] H Shanawani '*The Challenges of Conscientious Objection In Health Care'* (2016) 55 (2) *J Relig Health* 1.
[231] Ibid.

To resolve the problem, it is suggested that medical practitioners in these circumstances should advise patients of their views and then offer to transfer the patient and treatment to another medical practitioner or to remove themselves from the case[232].

2.8.5. Health Professions Council of South Africa Guidelines

Booklet 7 of the Health Professions Council of South Africa Guidelines, entitled, "*Guidelines for the Withholding and Withdrawing of Treatment*[233]" mentions advance directives and was created to assist medical practitioners when faced with an advance directive.

Within the introductory paragraph of these guidelines, it states that medical practitioners have the responsibility of ensuring and making the care of their patients their first concern[234]. It goes on further to provide that patients should be both encouraged as well as permitted the opportunity to express their wishes and preferences regarding their future medical treatment and care in an advance directive which would usually assume the form of a 'living will'[235]. They should place in writing how they wish to be treated medically in the event of any critical and unforeseen circumstances arising such as, a terminal illness or a permanent coma[236].

The Guidelines further state that patients should also be encouraged to appoint in writing an individual to make treatment decisions on their behalf when they are no longer able to do so themselves as this is in accordance with

[232] See note 14. (Section 7) 2.
[233] See note 5. 5.
[234] Ibid.5.
[235] Ibid. (Section 2.3) 6.
[236] Ibid.

the National Health Act[237]. To prevent ambiguity and uncertainty, the Guidelines explicitly provide that patients should be afforded the opportunity to review and reconsider their advance directive timeously and make any amendments to it if they wish at any given stage[238].

In the absence of advance directives, the guidelines state that the patient's closest family must be consulted before any decisions can be taken[239]. Thereafter, once consultation has taken place, a decision that is in the patient's best interest is taken[240].

In acute life threatening emergency situations where it is almost impossible to obtain all the relevant information required or to consult with other persons and this delay may prejudice the outcome of the patient's case, then health care practitioners should begin treatment beneficial to the patient until a final assessment of the patient can be reached[241]. This also applies to situations where the likelihood of recovery appears to be impossible or where uncertainty about the diagnosis exists[242].

All decisions ultimately reached should be clearly and fully documented in notes together with the reasons for arriving at that decision and the procedure adopted in the decision-making process[243]. Where disagreements arise regarding the patient's best interests and the course of medical treatment to be followed, the health care team responsible for the dying patient must consult with other health care professionals to obtain a clinical or ethical

[237] Ibid.
[238] Ibid.
[239] Ibid. (Section 2.4) 7.
[240] Ibid.
[241] Ibid. (Section 6.1) 7.
[242] Ibid.
[243] Ibid. (Section 2.7) 7.

review[244]. Alternatively, if this procedure fails, seeking legal advice on whether it would be necessary to apply to a court to pass judgment on the matter would be appropriate[245].

2.8.5.1. Patient's views

The patient's views are the most crucial factor in decision-making and are provided for in these guidelines. The guidelines state that patients should be informed about their condition, the treatment options available and which options are deemed to be in the patient's best interests according to their professional opinions[246]. Furthermore, the guidelines make it a priority that the ultimate decision to be taken rests on the patient after they have taken into consideration the risks, burdens and what they prefer to be in their best interests[247].

The guidelines further state that health care practitioners should respect decisions taken by mentally competent patients regardless if the decision results in them refusing to accept medical interventions and treatment and this would lead to the patient's death[248]. Where the possibility of withdrawing or withholding treatment is an option, health care practitioners should always consult with the patient regarding how care would be provided together with the palliative or terminal needs that would be required and how these needs shall be met[249]. Discussing the aforementioned with the patient provides the patient with an opportunity to make relevant decisions and arrangements about their personal, medical and other relevant matters or concerns[250].

[244] Ibid.
[245] Ibid.
[246] Ibid. (Section 7.1.1) 3.
[247] Ibid.
[248] Ibid. (Section 7.1.3) 4.
[249] Ibid. (Section 7.1.3) 8.
[250] Ibid. (Section 7.1.4) 4.

The guidelines suggest that the most appropriate time to consult and discuss matters with a patient is a time when the patient is in a good position to understand and retain the information being told to them[251].

2.8.5.2. The Refusal of Medical Treatment and Children

Where the terminally ill patient is a child, healthcare practitioners are obliged to respect their decisions regardless if it is accepting or refusing medical treatment unless the practitioner deems it necessary to intervene as it is not in the child's best interests[252]. In such a situation, approaching the court to make a ruling would be the best option[253]. In situations where a child lacks the required legal capacity to make a decision but is of sufficient mental maturity to understand what procedures are available and what each procedure entails then health care practitioners should consult with the child to reach an appropriate decision aiming to be a decision that would result in the child's best interests[254].

The following section will discuss the four principles of Biomedical Ethics in relation to advance directives and will provide a comprehensive summary of how such ethical considerations either influence or disregard advance directives.

2.9 Ethical Analysis of Advance Directives:

According to the principles of Biomedical Ethics, four underlying principles have been established which is used even in the modern era. Namely, that of autonomy, beneficence, non-maleficence and justice.

[251] Ibid. (Section 7.2.1) 8.
[252] Ibid. (Section 14.2) 7.
[253] Ibid.
[254] Ibid. (Section 14.4) 7.

2.9.1 Autonomy

The principle of autonomy is recognized in the Constitution, the National Health Act and the South African Common Law[255]. This principle entails having the authority to make your own decisions or choices independently and free from outside interferences or influences from anyone including and not limited to family, friends and even medical practitioners[256]. In summary, the decision to be made is taken solely by that person himself or herself as there are no limitations that are present in preventing one from undertaking that decision[257].

With regards to advance directives, the rule of autonomy entails that health care practitioners recognize and respect the decisions taken by mentally competent patients even if their choices are not consistent with that of their family, spouses, friends and physicians[258]. It allows for competent people to 'write-down' their preferences and wishes regarding life-sustaining treatment if they become terminally ill or as a result, end up in a permanent vegetative state in the future[259]. Thus, respecting a person's advance directive means respecting their decisions which is in conformity with the principle of autonomy[260]. However, a patient's autonomy can be limited in certain circumstances. Some circumstances would include where a patient requests a physician to engage in conduct that is unlawful, unethical or against the general duties of health care practitioners[261].

[255] See Note 16.38.
[256] E A Robert '*Who lives, Who Dies, Who Decides? : Legal And ethical Implications Of Advance Directives*' (1996) 7 (1) *Windsor Review Of Legal And Social Issues* 6.
[257] Ibid.
[258] Ibid.
[259] See Note 16.38.
[260] See Note 8.7.
[261] See Note 16.38.

In cases where the conduct amounts to a crime then the complying doctor cannot use the defence of stating that they were merely following the instructions of the patient in question with regards to the treatment or procedure being used[262].

2.9.1.1. Justifications For Limiting a Person's Autonomy

The following section hereunder will firstly, discuss the justifications for limiting an individual's autonomy and secondly, why it may not be viewed as being ethically justified overall.

Firstly, it is argued that, allowing a person to draft and have that said advance directive be legally recognised portrays or illustrates a message to the public that certain lives are not worth living[263]. Most often, it is the elderly, the disadvantaged and the disabled that draw up advance directives[264]. Thus, most organizations are concerned that the government would be conveying a message to the public that such decisions to end one's life requires no protection and should always be upheld no matter the situation[265].

However, to contrast the aforesaid, the ultimate decision to end one's life and to make the determination that life is no longer worth living is made by the elderly, disabled and disadvantaged people themselves[266]. Hence, when these categories of people make such a decision that the continued mental or physical suffering does not warrant them being kept alive by medical intervention, this decision should not be seen as harming the states interest[267].

[262] See Note 8.7.
[263] See Note 221.7.
[264] Ibid.
[265] Ibid.8.
[266] Ibid.7.
[267] Ibid.8.

Secondly, it is suggested that, a person's beliefs, choices, and concerns about their life may change over a period of time[268]. Some opponents of advance directives argue that, a person is speculating about feelings which are unknown at the time the advance directive is drafted[269]. Such a feeling might change in the future and one could realize that they prefer medical intervention rather than declining it[270]. Furthermore, it is a concern that a patient whose wishes may change regarding future medical treatment may forget to illustrate this change in their directive[271]. However, the fact that a patient may change his mind in the future should not be a bar against the drafting of an advance directive[272] or the legal recognition of one. If a competent patient is able to reflect their wishes at a particular time in the directive, then there is no reason to assume that a person's views have actually changed since the drafting of the directive[273].

It is suggested that, a policy of updating advance directives should be put in place so that, healthcare practitioners are aware of the current wishes of the patient and that they are following the true wishes of that patient[274]. In addition, patients should be informed at the time of drafting the directive, that they can alter or revoke it at any given time should their preferences change[275].

[268] Ibid.
[269] Ibid.
[270] Ibid.
[271] Ibid.10.
[272] Ibid.
[273] P A Singer '*Advance Directives: Are They An Advance?' (*1992) 146 (2) *Estates And Trusts Journal* 363.
[274] Ibid.361.
[275] Ibid.363.

To conclude, upholding a patient's autonomy in decision-making equals respecting their advance directive if they do become mentally incompetent in the future[276].

2.9.2. Beneficence

This principle entails healthcare professionals contributing to the welfare of their patients[277] and a moral obligation to act for the benefit of others[278]. The Hippocratic Oath extends back to the time of Hippocrates and is an oath embodying a code of medical ethics taken by those about to begin medical practice[279]. The Hippocratic Oath entails the principle of doing the least harm to the patient[280].

Currently, there is an updated version of the Hippocratic Oath in the Revised Declaration of Geneva which has been approved by the World Medical Association[281]. The Declaration of Geneva is not regarded as an oath but rather a 'pledge'[282]. This current Declaration is used across the world by a number of physicians and in some countries, this Declaration is considered to be legally binding[283].

An important clause amongst the many other clauses which has been introduced and inserted in the Declaration of Geneva deals specifically with patient autonomy. This clause has been inserted into the 2017 updated version

[276] Ibid.
[277] See Note 16.39.
[278] See Note 221.11.
[279] *Hippocratic Oath, Classical Version'* Available at http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.htmlAccessed on 17 May 2017.
[280] See note 221.11.
[281] M Cook 'New Hippocratic Oath For Doctors Approved' (2017) Available at https://www.bioedge.org/bioethics/new-hippocratic-oath-for-doctors-approved/12496 Accessed on 10 January 2019.
[282] Ibid.
[283] Ibid.

which reads, "I will respect the autonomy and dignity of my own patient"[284]. As can be seen from the wording of the clause, it is clearly emphasised that patients are free to make their own decisions with regards to their health and or healthcare[285]. Dignity is also included and emphasised in the afore-mentioned clause as it requires healthcare practitioners to uphold their patients dignity at all times and not to undermine it or force patients to live a life that is not worth living[286].

By respecting and upholding a patient's directive means that death of the patient is more likely to occur and some physicians may feel that this goes against their Hippocratic Oath as they do not wish their patients death but instead, to heal their patient so that they may live longer[287]. Physicians are always expected to act in the best interests of their patients thus, with their superior knowledge they are allowed to make decisions that will benefit the patient[288].

However, in the modern era, patients are now playing a more active role as they have a better understanding of their illnesses and diseases preferring to make choices of their own regarding their medical treatment[289]. Though, physicians are expected to know better and do the least harm, the principle of beneficence is still upheld as well as supports the notion of advance directives because ultimately, the patient is making a decision for the benefit of themselves and respecting their wishes means that physicians are acting for the benefit of their patients[290]. The Declaration of Geneva supports the aforesaid argument based on the clause of autonomy which is inserted in the

[284] Ibid.
[285] Ibid.
[286] Ibid.
[287] See Note 221.11.
[288] Ibid.
[289] Ibid.11-12.
[290] Ibid.12.

Declaration. Doctor Yoshitake Yokokura who is the President of the World Medical Association stated that, "the life of physicians today is completely different to what it was in 1948 when the original Declaration of Geneva was adopted. Since then, the Declaration has become a core document of medical ethics and a modern version of the 2 500 year old Hippocractic Oath"[291]. This statement takes into account that the modern generation is evolving and both the patients as well as the physician's views will differ from the past[292].

It has been argued that the duty on physicians to preserve life does not entail preserving life at all costs without taking the quality of the patient's life into consideration[293]. Where a patient is merely in a state of existence, then ending that patient's life at their request may be viewed as being in line with the principle of beneficence[294].

2.9.3. Non-maleficence

This principle linked to that of beneficence means that physicians should not unnecessarily harm their patients[295]. A harm that may result is by a patient refusing to accept medical treatment which in turns portrays to society and the public that life is not sacred[296].

It has been argued that a potential harm exists amongst the survivors of the patient who had drafted the directive and is no longer alive[297]. Some families, relatives and friends have argued that, precious time is lost as a result of treatment not being administered or treatment being withdrawn[298]. They

[291] See Note 246.
[292] Ibid.
[293] See Note 16.39.
[294] Ibid.
[295] Ibid.
[296] See Note 221.12.
[297] Ibid.
[298] Ibid.

concede that they prefer having the patient alive even though they are terminally ill and cannot respond[299].

However, although family, relatives and friends have personal choices, feelings and sentiments regarding the patient and that they would prefer having the patient 'alive' does not mean that they should be considered only with no regard to the patient himself/herself[300]. Following a patient's directive might prove beneficial in that, the survivors of the patient may genuinely have a sense of relief knowing that the person they love is no longer suffering and is not subject to prolonged suffering[301].

Having a directive also takes away the emotional hardship of having to make a decision involving life and death of the patient[302]. The families, relatives or friends are assured that they are acting in accordance with the patient's wishes and that they are merely being supportive and understanding of the patient's ultimate decision[303].

A further argument raised is that physicians, nurses and other patients may experience harm emotionally[304]. Knowing that their patient's life can be pro longed instead of terminating it may harm the consciousness of health care professionals[305].

2.9.4. Justice

This principle entails that physicians must treat their patients fairly and without discrimination at all times[306]. In the modern era, the issue of scarce

[299] Ibid.
[300] Ibid.
[301] Ibid.
[302] Ibid.
[303] Ibid.12-13.
[304] Ibid.13.
[305] Ibid.
[306] See Note 16.39.

resources is now a major concern. It is stated that using resources to keep someone alive who wishes to die could be seen as irresponsible and also as "conflicting with the interests of others who may be denied treatment as a result"[307]. In the case of *Soobramoney*[308], it was argued that the withholding of dialysis of the kidneys led directly to the applicant's death. As mentioned by the judge in the case of *Stransham-Ford*[309], the irony again is that, the state sanctions death when it is bad for a person but denies it when it is good. Therefore, the point to be noted is that, patients who want to die should be allowed to die in a dignified manner so that resources could be used on patients that are actually in severe need of it and who could be cured but is unable to get access to these resources rather, than being used on patients illustrating no sign of recovery at all[310]. Hence, the principle of justice mandates the use of advance directives in order to avoid the drainage on limited health care resources[311].

2.10. Conclusion

This chapter has focused on the current legal position of advance directives in South Africa. As mentioned above, South Africa has no definite legislation that regulates the implementation and use of advance directives though South African Law has a limited number of guidelines and policies that do deal with advance directives to an extent[312] hence, the possibility of liability to a medical physician always exists[313]. The case of *Clarke*[314]was the first South African case to mention advance directives however, even though the court in this specific

[307] S Mclean & A Britton *Physician Assisted Suicide* (1997) 31.
[308]*Soobramoney v Minister of Health, Kwazulu-Natal* 1998 (1) SA 765 (CC).
[309]*Stransham-Ford v the Minister of Justice And Correctional Services And Others* 2015 (3) ALL SA 109 (GP).
[310] See Note 272.31.
[311] See Note 221.13.
[312] See Note 4.940.
[313] Ibid.
[314]*Clarke* supra.

case accepted the practitioner's living will and ordered the withdrawal of treatment, it did not address the question of living wills and left the situation regarding advance directives unclear[315].

The South African Constitution[316] plays a vital role when it comes to advance directives as it entails a number of rights[317] that an individual is entitled to. An individual can rely on these rights as contained in the Constitution in order to draft and have their directives respected at all times. These rights can never be infringed upon but may however be limited in terms of Section 36 of the Constitution[318].

Informed consent of a patient is extremely important and necessary before any medical treatment or procedures can be conducted on a patient. Lastly, as already mentioned, South Africa has policies and draft legislation in place, that are merely used to guide physicians when it comes to being faced with a patient's advance directive or either, assisting an individual to draft one.

The next chapter will focus broadly on international law and the legal position of advance directives specifically in the jurisdiction of Canada.

[315] See note 4.938.
[316] The Constitution of The Republic of South Africa, 1996.
[317] The rights referred to are the right to dignity (Section 10), the right to life (Section 11), the right to privacy (Section 14) and the right to freedom and security of the person (Section 12(1)) all found within Chapter 2 of the Constitution of The Republic of South Africa, 1996.
[318] The Constitution of The Republic of South Africa, 1996.

CHAPTER 3

THE CURRENT LEGAL POSITION OF ADVANCE DIRECTIVES IN CANADA

3.1. Introduction

The legal validity of advance directives in Canada is clear as many provinces within Canada such as Nova Scotia, Newfoundland, Ontario and Manitoba have enacted legislation which gives legal recognition and effect to such documents[319]. Where ambiguity arises, the situation is unclear or where no legislation has been enacted to regulate advance directives in certain parts of Canada, the common law prevails[320]. In other words, where a valid refusal of medical intervention or treatment is requested through a document, it must be upheld and followed as the instructions contained therein are considered legally valid wishes of the patient which is to be respected by physicians treating such patients[321].

Canadians are increasingly portraying interest in expressing their wishes regarding future medical care and treatment should they become incapable or incompetent[322]. Amongst Canadian citizens, 10% of them have completed advance directives and a further 10% have spoken to their family physician regarding their end of life decisions and medical care or treatment[323]. In

[319] See Note 221.
[320] Ibid.
[321] Ibid.
[322] Canadian Medical Association '*Advance Care Planning*' (2017) 1 Available at *https://www.cma.ca/Assets/assets-library/document/en/advocacy/cma_policy_advance_care_planning_pd17-04-e.pdf* Accessed on 11 November 2017.
[323] A Horvat '*Issues In Bioethics: Advance Directives In A Canadian-Croatian Perspective*' (2012) 1 (2) *JAHR* 326.

addition, 40% of Canadians have discussed their last wishes and preferences with their next-of-kin[324].

3.2. The Common Law

The right to refuse medical intervention or treatment is a pro founded principle in common law and any physician who fails to obtain prior informed consent can be held liable on the grounds of battery or negligence through civil actions being issued against them[325].

Though not directly related to advance directives, the case of *Mulloy v Hop Song*[326] is applicable to the common law principle. In this case, Hop Song (the patient) explicitly informed the treating physician that he did not want his hand to be amputated at no costs. Instead, he just wanted his hand to be 'fixed'[327]. In other words, he requested the treating physician treat his hand with the utmost care and without involving any surgery or amputations[328]. A while later, even in the operating room, the patient repeated his instructions of not wanting his hands to be amputated[329]. The physician then proceeded to amputate his hand as he stated that such amputation was necessary because any further delay would mean blood poisoning resulting in no way of saving the patients hand[330].

The court held that, the patient was entitled to recover damages from the physician because the patient gave clear, expressed wishes twice that he did not want his hand to be amputated and by going against said wishes,

[324] Ibid.
[325] S MacKenzie '*Informed Consent: The Right Of Psychiatric Patients To Refuse Treatment*' (1993) 2 (59) *Dalhouise Journal Of Legal Studies* 59-60.
[326] *Mulloy v Hop Sang (1935) 1 WWR 714*
[327] Law And Medicine, *Battery* (2008) Available at http://www.pedsoncologyeducation.com/LawOverviewBattery.asp Accessed on 29 October 2018.
[328] Ibid.
[329] Ibid.
[330] Ibid.

constituted battery and trespassing on behalf of the physician[331]. The court held further that, even in instances where the medical treatment is necessary and where it improved the situation, going against the wishes of the patient results in battery[332].

Therefore, as can be seen from the above mentioned case, though the patient did not have an advance directive in place, it can be argued that this case supports and advocates for advance directives as the court agreed with the fact that the patients instructions should have been respected[333]. Even though the patient whilst still mentally competent had given instructions to the treating physician only moments before the procedure, it can be argued that this instruction solely should have been respected as it is in accordance with the ethical principle of autonomy in that the patient had a right to refuse to be amputated at no costs as this was his wish and this wish or desire should have been upheld.

The first case to deal with the issue of advance directives under Canadian law was the case of *Malette v Shulman[334].* In this case, Malette (the applicant) met with an accident in which she suffered serious injuries and was diagnosed as suffering from hypovolemic shock. Due to this suffering, she was given intravenous fluids to assist in replacing the blood she had already lost[335]. At or around the same time, a nurse discovered a card in her purse identifying her as a Jehovah's Witness and which clearly stated that, she should not be given any blood or blood products at any given circumstances due to her religious beliefs[336]. However, despite her request on the card, the doctor treating the

[331] Ibid.
[332] Ibid.
[333] Ibid.
[334] *Malette v Shulman* (1990) 72 O.R (2d) 417 (C.A).
[335] See Note 221.14.
[336] Ibid.15.

applicant who was doctor Shulman at the relevant time (the defendant) went ahead and administered her with several units of blood against her wishes[337]. The applicant then sued the defendant for not obeying her wishes which was clearly illustrated on her card and for proceeding to administer her with blood transfusions[338]. She argued that the blood transfusions constituted negligence, assault, battery and religious discrimination.

The court in this case awarded $ 20 000 for the mental and emotional harm and suffering the applicant had to undergo due to the doctor acting against her valid wishes[339]. Important to note is that the court in this case supported the applicants right to make treatment decisions for herself even if it did not comply with that of the medical practitioner and recognized her card as being a valid advance directive and an expression of her request which clearly prohibited the defendant from administering blood transfusions[340].

The judge in this case further remarked that a doctor or any health care practitioner is not free to disregard a patient's advance directive, wishes or instructions at any given time regardless if the situation is an emergency one[341]. The court also affirmed the common law principle that no person is free to invade or interfere with another person's bodily integrity without their informed consent at no given circumstances[342].

This case was one of the most precedential cases in Canada as it opened the doors to legal recognition of advance directives by giving medical practitioner's

[337] Ibid.
[338] Ibid.
[339] Ibid.
[340] Ibid.
[341] Ibid.
[342] Ibid.

the "green light to honour" such advance directives[343]. Furthermore, after the court ruled in this case, public consciousness was heightened amongst Canadian citizens as they were fully aware of the importance of advance directives resulting in numerous Canadians implementing advance directives[344]. It has been argued that since this decision, advance directives have been used frequently and a number of provinces within Canada including, Saskatchewan have enacted legislation governing their uses[345].

3.3. Legislation and policies Regulating Advance Directives

3.3.1. Canadian Charter of Rights and Freedoms

The Canadian Charter of Rights and Freedoms[346] was enacted in 1984 and can be described as being 'part' of the Canadian Constitution which sets out the rights and freedoms a person has in a free and democratic society within Canada. The following sections of the Charter are the most important with regards to advance directives under Canadian Law.

3.3.1.1. Section 2 (a) of the Charter reads: "2. *Everyone has the following fundamental freedoms:*

(a) Freedom of conscience and religion"[347]*.*

It has been argued that the right to refuse medical intervention and treatment through advance directives stems from a person's conscience more than their

[343] See Note 272.326.
[344] See Note 221.16.
[345] See Note 272.326.
[346] *Canadian Charter Of Rights And Freedoms*, Part 1 of The Constitution Act, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.
[347] Ibid. Section 2(a).

religion[348]. A terminally ill individual ultimately decides about their quality of life and what decisions should be taken[349]. However, sometimes individuals draw up advance directives based on their religious views and perceptions[350].

3.3.1.2. Section 7 of the Charter reads:

"*Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice"*[351].

The aforementioned section of the Charter is of importance because the right to liberty equals the right to refuse medical treatment through an advance directive[352]. It allows for a terminally ill individual to make informed decisions regarding their health, treatment options available and to determine what their limits of an unbearable quality of life would be[353]. Furthermore, the right to liberty ensures that the personal autonomy of the terminally ill individual is respected at all times without the interference of another[354].

The right to security of the person ensures that both the psychological and physical integrity of the individual is upheld and that they have complete control over their own body[355].

3.3.1.3. Section 12 reads:

"*Everyone has the right not to be subjected to any cruel and unusual treatment or punishment*"[356].

[348] See note 221.23.
[349] Ibid.
[350] Ibid.
[351] See Note 311.Section 7.
[352] See Note 221.24.
[353] Ibid.
[354] Ibid.
[355] Ibid.
[356] See Note 311.Section 12.

It has been suggested that denying a person the option to draft their own advance directive amounts to cruel and unusual treatment or punishment[357]. Furthermore, refusing to uphold the advance directive if drafted and is already in existence amounts to punishment on its own as every individual has a right to be treated in accordance with their wishes and preferences[358].

3.3.1.4. Section 15 (1) reads:

"*Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability"*[359].

If a physician refuses to uphold an advance directive due to the fact that it is an elderly person, a child or people who are physically or mentally disabled that has drafted it then such a decision amounts to discrimination[360].

3.4. Policy of Advance Care Planning

The Canadian Medical Association introduced a policy entitled '*Advance Care Planning'*[361]to provide guidelines to both physicians and patients regarding advance directives. It was also implemented to enhance the knowledge of Canadian citizens by making them aware of the current legislation within Canada and the importance of having advance directives in place[362]. The main aim of this policy is to advise physicians to assist their patients to complete advance directives if they are requested to do so and to honour such directives

[357] See Note 221.26.
[358] Ibid.
[359] See Note 311.Section 15(1).
[360] See Note 221.26.
[361] See Note 271.
[362] Ibid.2.

unless reasonable grounds exist to portray that such wishes do not represent the current wishes of the patient[363].

Advance care planning can be described as a process whereby physicians communicate with their patients in order to determine what their wishes or preferences regarding medical care and treatment would be if they become incapable or incompetent to make decisions[364]. It is also a process of involving discussions with the patient's family, friends or relatives[365]. The end result of such discussions leads to the drafting of an advance directive of the patient[366]. The policy emphasizes the autonomy and dignity a patient has in decision-making and states that utmost respect should be given to such decisions at all times by the treating physician[367].

3.5. The Mental Health Act[368]

Nova Scotia was the first province in Canada to pass laws providing for the enactment and implementation of advance directives[369]. This province was also the first province to recognize the right of involuntary patients to refuse medical treatment[370]. Competent patients may refuse to accept treatment or medical intervention in psychiatric facilities even if they are involuntary detained[371].

After the passing of the Mental Health Act in 1977[372], Manitoba amended their Mental Health Act in 1986 to state that involuntary patients may refuse

[363] See Note 272.326.
[364] See Note 271.2.
[365] Ibid.
[366] Ibid.
[367] Ibid.
[368] *The Mental Health Act* of 1977.
[369] T G Gratzer& M Matas '*The Right To Refuse Treatment: Recent Canadian Developments'* (1992) 22 (2) *Bulletin Of The American Academy Of Psychiatry And The* Law 250.
[370] Ibid.
[371] See Note 274.250.
[372] *The Mental Health Act* of 1977.

treatment if they are competent to make treatment decisions or medical care decisions[373]. Section 27 of the Act states that, the attending physician shall determine whether the patient is mentally competent to make treatment decisions regarding their healthcare once they have been admitted to a psychiatric facility[374]. In addition, Section 27 also provides that the attending physician must consider various aspects when determining a patient's competency[375]. Some aspects include whether the patient understands the condition for which the treatment is proposed[376], the nature as well as purpose of the treatment[377], risks and benefits involved in such treatment[378] and whether, the patients mental condition affects their ability to appreciate the consequences of that decision[379]. A physician who is of the opinion that a patient is not mentally competent to make treatment decisions in the facility must issue a certificate stating incompetency together with the reasons for such and file it with the medical director[380].

3.6. The Ontario Mental Health Act[381]

The Ontario Mental Health Act of 1987 recognizes the right of competent patients to refuse medical treatment regardless if they are involuntarily detained[382]. The case of *Fleming v Reid*[383] was the first Canadian case which

[373]The Mental Health Act C.C.S.M. cM110 '*Part 4: Treatment Decisions'* Section 26. Available at http://web2.gov.mb.ca/laws/statutes/ccsm/m110e.phpAccessed on 11 November 2017.
[374] Ibid. Section 27(1).
[375] Ibid. Section 27(2).
[376] Ibid. Section 27(2) (a) (i).
[377] Ibid. Section 27(2) (a) (ii).
[378] Ibid. Section 27(2)(a)(iii).
[379] Ibid. Section 27(2)(b).
[380] Ibid. Section 27(3).
[381]*The Ontario Mental Health Act* of 1987.
[382] See Note 274.250.
[383]*Fleming v Reid (1991) 4 O.R. (3d) 74 (C.A.).*

extended the common law right to mentally ill patients and the first case to protect such rights under the Charter[384].

In the case of *Fleming v Reid[385],* two psychiatric patients suffered from schizophrenia and were involuntarily detained at a psychiatric facility against their wishes. Their doctor who was also the director of the institution, felt that the patients were not competent enough to consent to psychiatric treatment or medication but would benefit from neuroleptic drugs if administered to them[386].

However, both patients whilst being in a competent state decided that they did not want to be administered with this kind of treatment due to the harsh side effects. The doctor then appealed to the review board under the provisions of the Mental Health Act[387] to administer the patients with neuroleptic drugs and the review board authorized such treatment as being in the patients' best interests[388]. The two patients then sued the doctor for administering the treatment to them without their duly informed consent.

The Ontario Court of Appeal made reference to Section 7 of the Charter of Rights and Freedoms and held that, the common law right to bodily integrity is a fundamental right and should be afforded the highest degree of protection and should be respected[389]. The court held further, that a patient's prior consent wishes given at the time they are competent should override the best interests of the patient as such decisions taken by patients regarding their future medical treatment is highly recognized and upheld[390].

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[384] See Note 294.
[385] *Fleming* supra.
[386] See Note 221.16.
[387] *The Mental Health Act* of 1977.
[388] Ibid.
[389] Ibid.17.
[390] Ibid.

Another similar case as to the aforementioned case was the case of, *Sevels V Cameron*[391]. In this case, the patient was suffering from paranoid schizophrenia and had made a prior, expressed competent wish that any neuroleptic drugs be rejected[392]. The court in this case held that, "wishes are not a mere factor in best interests. They are the expression of the right of individuals to determine what shall be done with their bodies"[393]. Hence, as can be seen from the courts statement, advance wishes be respected at all times.

3.7. The Health Care Consent and Care Facility Admission Act[394]

This act governs the consent to health care amongst Canadians and applies to all adults who are 19 years of age and older but not to children or patients who are involuntary admitted to a psychiatric hospital under the Mental Health Act[395].

Informed consent is vital and the Act provides that informed consent is necessary before providing any treatment or conducting any procedures to patients[396]. It states that, health care providers must inform the patient about the possible diagnosis, the proposed treatment, benefits of the treatment and the risks[397].

3.7.1. Consent Rights

Part 2, Section 4 of the Act provides for consent rights. It states that, "Every adult who is capable of giving or refusing consent to health care has

[391] *Sevels v Cameron (1995) O.J. No.381 (Ontario Court of Justice-General Division).*
[392] D L Ambrosini& A G Crocker '*Psychiatric Advance Directives and The Right To Refuse Treatment In Canada'* (2007) 52 (6) *The Canadian Journal of Psychiatry'* 398.
[393] Ibid.
[394] The Health Care Consent And Care Facility Admission Act (RSBC 1996) Available from http://www.bclaws.ca/civix/document/id/consol27/consol27/00_9681_01 Accessed on 20 March 2018.
[395] Ibid. Part 1, Section 2.
[396] Ibid. Part 2, Section 5(1).
[397] Ibid. Part 2, Section 6.

(a) The right to give consent or to refuse consent on any grounds, including moral or religious grounds, even if the refusal will result in death,
(b) The right to select a particular form of available health care on any grounds, including moral or religious grounds,
(c) The right to revoke consent,
(d) The right to expect that a decision to give, refuse or revoke consent will be respected and
(e) The right to be involved to the greatest degree possible in all case planning and decision-making"[398].

Therefore, as seen from above, it is clear that adults have a right to refuse medical treatment if they do not wish to be given such treatment[399]. Adults can refuse treatment for any reason even including and not limited to moral and religious reasons[400]. However, to be able to refuse treatment, one needs to be capable of understanding the nature and consequences of such refusal[401].

3.7.1.1. *Cuthbertson v Rasouli* (2013)[402]

Though this case does not deal directly with the topic of advance directives, important points relating to the concept of advance directives emerged within Canadian law. Mr Rasouli (the patient) went for a benign brain tumour procedure which can be defined as a procedure removing cells that grow at a slow pace in the brain eventually forming into a tumour however, he

[398] Ibid. Part 2, Section 4.
[399] Ibid.
[400] Ibid.
[401] Ibid.
[402] *Cuthbertson v Rasouli 2013 SCC 53*

developed an infection causing permanent brain damage[403]. He then ended up in a permanent vegetative state and was been kept alive by a ventilator. The treating physicians responsible for his care believed that all appropriate medical treatment for his condition had been exhausted, resulted in no hope for his recovery and was thus futile[404]. The physicians sought to remove the life-support and provide palliative care until his expected death.

Ontario's law states that where a person is legally incapable of making their own treatment decisions, then a Substitute-Decision Maker must be referred to in order to make all the relevant treatment decisions further, consent needs to be obtained from said Substitute-Decision Maker[405]. In this case, the patient's wife was the Substitute-Decision Maker[406]. The patient's wife and Substitute-Decision Maker refused to provide consent and applied to the Ontario Superior Court for an order restraining the physicians from withdrawing the patient from life-support without her said consent which was required in terms of the Health Care Consent and Care Facility Admission Act and that any challenges or oppositions brought forward in relation to her refusal be directed to the Consent and Capacity Board ("The Board")[407].

a. <u>The Superior Court of Ontario's Decision:</u>

This court held that the withdrawal of treatment is indeed considered treatment and thus, required the necessary consent from the Substitute-Decision Maker. The court held further that the matter be taken before to the Board for the ultimate decision.

[403] L Feldstein, '*What does the Rasouli Decision Mean for Families In Ontario*?' (2015) Available at http://canliiconnects.org/en/commentaires/37445 Accessed on 24 October 2018.
[404] Ibid.
[405] Ibid.
[406] Ibid.
[407] Ibid.

b. The Court of Appeal of Ontario:

The Physicians then appealed to the courts trial decision taken earlier and took the matter to the Ontario's court of Appeal who also re-affirmed the trial judge's decision that consent was vital[408].

c. The Supreme Court of Canada:

The majority of this court agreed that consent was vital and required however, two judges disagreed and gave a differing opinion. They held that, the Court and not the Board is the correct place for resolving disputes that arise between incapable patients and the Substitute-Decision Maker[409]. The court held that, Substitue-Decision Makers and families do not always get to make the final decision regarding the withdrawal of life support[410]. If physicians are of the opinion that the Substitute-Decision Makers are making the incorrect decision they are then entitled to apply to the Board for assistance[411].

3.7.2. How is this case then important in relation to advance directives?

As stated by the judge, the patient in this case had no advance directive in place and had not expressed a prior applicable wish which could be relied upon to resolve the disputes that had arisen between the physicians, the family's wishes and or the Substitue-Decision Maker and lastly, the courts[412].

Therefore, this case serves as a reminder for all individuals to reflect their end of life wishes and preferences in writing so that their loved ones are aware of such wishes if ever an unforeseeable situation has to arise rendering them incompetent[413]. It is also suggested that, power of attorneys be drafted to

[408] Ibid.
[409] Ibid.
[410] Ibid.
[411] Ibid.
[412] Ibid.
[413] Ibid.

provide clarity and remove any ambiguity so that a persons loved ones are free from the burden of having to make the decision, free from emotional pain and free from money used for litigation which could take years for the courts to arrive at a decision[414].

Lastly, It can be seen from this case that although Substitute-Decision Makers can be appointed, a terminally ill patient or an incapable patient can be relieved knowning that the decisions taken by said Substitute-Decision Makers can always be reviewed if the treating physicians are not of the same opinion[415].

3.7.3. The Implementation of advance directives

Part 2.1, provides for the enactment of advance directives. The formalities for the drafting of a directive indicates that, the directive must be in writing, signed and dated by the individual himself and two other witnesses all present at the same time[416]. However, if the witness is a lawyer then only one witness is sufficient for the purposes of this Act[417]. The Act also makes provision for the revocation of directives. It states that an individual who has made the directive may at any time change or revoke the directive unless that individual is incapable of understanding the nature and consequences of such change or revocation[418]. To make the revocation valid, it has to be conducted in writing, signed and witnessed by two witnesses[419].

The Act states that an adult may make a directive unless that adult is incapable of understanding the nature and consequences of such directive[420]. It goes on

[414] Ibid.
[415] Ibid.
[416] See Note 359. Part 2.1, Section 19.5 (1)(a)-(b).
[417]Ibid. Part 2.1, Section 19.5 (4).
[418]Ibid. Part 2.1, Section 19.6 (1).
[419] Ibid. Part 2.1, Section 19.6 (2).
[420] Ibid. Part 2.1, Section 19.1 (1).

further to state that, an adult may either give or refuse consent to any health care described in that directive[421]. However, an individual cannot have a directive that permits the physician to do both[422]. In other words, if a directive allows for both the refusing and consenting to medical treatment at the same time then, such a provision is to be severed from the directive[423].

If the patient consents to medical treatment in the directive then, the physician is obliged to provide that patient with the appropriate and necessary treatment[424]. However, if the directive contains a clause refusing medical treatment then, the physician is obliged not to provide any sort of medical treatment on the patient[425].

If health care providers are unaware that a patient does have a directive in place that refuses consent to medical treatment and goes on to providing medical treatment to that patient and subsequently, becomes aware of the directive then such a health care provider is obliged to withdraw treatment at the earliest[426]. Lastly, health care providers are protected from any civil or criminal actions that could be brought against them if they have acted in good faith, used reasonable care and did not act negligently[427].

When a physician has to decide whether an adult is incapable of giving, refusing or revoking consent to health care, such physician has to base their decision on whether or not the adult understands the information given to them and the possible proposed medical treatments that are applicable to the

[421]Ibid. Part 2.1, Section 19.2 (1).

[422] Ibid. Part 2.1, Section 19.2 (2).
[423] Ibid.
[424] Ibid. Part 2.1, Section 19.7 (2)(a).
[425]Ibid. Part 2.1, Section 19.7 (b).
[426] Ibid. Part 2.1, section 19.9 (a)-(c).
[427] Ibid. Part 5, section 33(1).

situation at hand[428]. If the physician arrives at the outcome that the patient is incapable of reaching a decision then, such physician is permitted to provide minor medical treatment without the patients consent[429].

3.8. The Personal Directives Act[430]

The Personal Directives Act is a statute that allows for the recognition of a personal directive as a legal document in Nova Scotia[431]. The purpose of this statute is to enable the people of Nova Scotia to draft a personal directive pertaining to all their future treatment and decisions to be made in the event of them becoming incompetent[432]. The Act also allows for individuals to appoint delegates or substitute decision-makers to make decisions on their behalf in the event of them becoming incapacitated in the future[433].

More specifically, this Act permits individuals to make a personal directive setting out their instructions, values, beliefs or wishes regarding future personal-care decisions to be made on their behalf and authorising one or more persons to act on their behalf and make decisions regarding their personal care[434]. They can make a personal directive as long as they have the required capacity to do so[435].

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[428] Ibid. Part 2, Section 7(a) (b)(e).
[429] Ibid. Part 2, Section 15(a).
[430] The Personal Directives Act (Chapter 8 of 2008) Available at https://nslegislature.ca/sites/default/files/legc/statutes/persdir.htmAccessed on 11 April 2018.
[431]The Personal Directives Act *'Frequently Asked Questions'* 1 Available at *https://www.google.co.za/url?sa=t&source=web&rct=j&url=https://www.healthassociation.ns.ca/DocumentViewer.aspx%3FportalName%3Dbase%26disposition%3Ddefault%26elementId%3D116911&ved=2ahUKEwjwKfapbLaAhUnIsAKHeC-B80QFjAEegQIABAB&usg=A0vVaw2T4t9t9qUwTMIxDQt-9GGnvG*Accessed on 11 April 2018.
[432]Ibid.
[433] Ibid.
[434] See Note 368. Section 3(1) (a)(b).
[435] Ibid. Section 3(1).

3.8.1. Formalities and requirements for an advance directive

This Act requires the directive to be in writing, dated and signed by the maker[436]together with a witness who must not be the same person delegated to make decisions for the maker[437]. If the maker is unable to sign the directive then, a person who is neither the delegate nor the spouse of said delegate is permitted to sign the directive on behalf of the maker[438]. If the directive is drafted as per the requirements mentioned in the Act then, the directive is regarded as being a legally valid document and comes into effect when the maker of such directive lacks the necessary capacity to make the required personal-care decisions[439].

Only one person can be named as the delegate however, where the directive indicates that two delegates are appointed then, each of the delegates must be assigned a different duty with regards to the decision-making[440]. A person may make more than one directive[441] and if either of these directives conflict with another then, the later and updated directive will apply[442]. However, instructions that are prohibited by law are void and invalid[443].

This personal directive loses its effect when the maker has capacity[444], when the directive is revoked by the maker having the required capacity and such revocation is reduced to writing[445] and if the court declares the directive to cease its effect[446]. A delegate's authority ceases when the delegate resigns,

[436] Ibid. Section 3(2).
[437] Ibid. Section 3(3).
[438] Ibid. Section 3(2).
[439] Ibid. Section 9.
[440] Ibid. Section 5.
[441] Ibid. Section 4(1).
[442] Ibid. Section 4(2).
[443] Ibid. Section 5(3).
[444] Ibid. Section 12(1)(a).
[445] Ibid. Section 12(1)(c).
[446] Ibid. Section 12(1)(d).

dies or lacks the required capacity to make personal-care decisions[447], where the maker of the directive revokes the delegate's authority[448] and where the court declares the delegate to have no authority[449].

3.8.2. Position when no advance directives are applicable

In the absence of instructions, the delegate is required to act in a manner that accords to the maker's wishes and beliefs[450]. In other words, the delegate must make a decision that they believe would be in accordance to the maker's wishes or beliefs[451]. If the delegate is unaware of the maker's beliefs or wishes then, they must make a decision that is in the best interests of the maker[452]. A health care provider is obliged to follow any instructions by the delegate who is acting in accordance with this Act[453].

Where there is no delegate then the health care provider shall follow the instructions or expressions of the maker's wishes contained in the directive[454]. Where there is no personal directive at all then the health care provider shall follow the instructions by a statutory decision-maker in accordance to this Act[455]. In other words, if an individual does not identify a delegate or becomes incapacitated and has not created a directive naming a delegate then, the service provider providing the health care service has the authority to determine the appropriate substitute decision-make based on the hierarchy in the Act[456].

[447] Ibid. Section 13(a).
[448] Ibid. Section 13(b).
[449] Ibid. Section 13(c).
[450] Ibid. Section 15(2)(b).
[451] Ibid.
[452] Ibid. Section 15(1)(c).
[453] Ibid. Section 18 (3)(a).
[454] Ibid. Section 18 (3)(b)
[455] Ibid. Section 18 (3)(c)
[456] See Note 368.3. (See Appendix A for the hierarchy of the Act).

3.8.3. Physician's liability

No action lies against any person acting in good faith and by upholding and honouring the personal directive in question[457]. This includes the delegate, statutory decision-maker and the health care provider[458].

Courts are forbidden to add or alter any existing personal directives as it may change the original intention of the maker[459]. The court is only permitted to alter the directive if it is satisfied that the maker's instructions or wishes have changed since the drafting of the directive[460].

3.9. Personal Directives Act, A Guide For Licensed Practical Nurses[461]

These guidelines have been developed to assist licensed practical nurses when faced with personal directives so that they are able to act accordingly in relation to the code of ethics and standards of practice to which they are bound[462]. However, these guidelines clearly state that they are to be used in conjunction with other relevant statutes and guidelines to enhance the nurses knowledge[463]. These guidelines merely reiterate the Personal Directives Act[464].

The guidelines begin by defining a personal directive. It then goes on to state that the Act enables individuals to do three things:

[457] See Note 368.Section 20(a).
[458] Ibid.
[459] Ibid. Section 31(3).
[460] See Note 378.
[461] College Of Licensed Practical Nurses Of Nova Scotia '*Personal Directives Act: A Guide For LPN's'* (2018) 1 Available at *https://www.google.co.za/url?sa=t&source=web&rct=j&url=http://clpnns.ca/wp-content/uploads/201801/PDA-2018f.pdf&ved=2ahUKEwiCx-7borLaAhWMCMAKHagoCIQQFjAAegQIBxAB&usg=AOvVaw2hkkGyZtWOGOqrc6D3TQ5n*Accessed on 11 April 2018.
[462] Ibid.
[463] Ibid.
[464] See Note 378.

- It permits individuals to make a directive containing all their future decisions, plans or wishes about their future and how decisions are to be made in the event of them becoming incapacitated[465].
- It permits individuals to appoint a delegate and/or substitute decision-maker to make decisions on their behalf in the event of them becoming incapacitated[466]. Decisions include amongst others, those related to healthcare, nutrition, hydration, shelter and clothing[467].
- It provides for a hierarchy of statutory substitute decision-makers where the individual has no directive in place[468].

The guidelines then go on to state the formalities for a personal directive to be valid and legal[469]. It defines the terms delegate, substitute decision-makers and capacity[470].

Lastly, it ends with the role of nurses and what they have to do in order to ensure that they are providing the treatment safely and in accordance to the patient's wishes or instructions[471]. It states that nurses have to determine if a patient has a personal directive in place and if they do, they are then obliged to place a copy of it on the patient's record and thereafter, communicate as well as make more copies to the rest of the health team treating the patient[472]. The nurses have to also determine whether that patient has the capacity to make decisions and if they do, obtain their informed consent[473]. If the nurse determines that the patient has no capacity then, they have to inform as well

[465] See Note 396.
[466] Ibid.
[467] Ibid.
[468]Ibid. (See Appendix A for the hierarchy of the Act).
[469] Ibid.2.
[470] Ibid.
[471] Ibid.3.
[472] Ibid.
[473] Ibid.

as consult with an appropriate person who is normally the delegate or substitute decision-maker in order to ensure the patient's wishes are being adhered to[474].

3.10. Advance Health Care Directives Act[475]

On the 1 July 1995, the government of Newfoundland in Canada enacted the Advance Health Care Directives Act and this Act recognises advance directives by either the appointment of a proxy or by instructional directives or both[476]. This Act is similar to the Personal Directives Act that was introduced in Nova Scotia and most of the Act reiterates the Personal Directives Act.

Part I of the Act deals with advance health care directives. It states that a person who is competent can make a directive setting out their instructions regarding their medical treatment or setting out general principles regarding the type of health care they want[477].

In addition, it states that if a person is competent enough to make healthcare decisions then they are permitted to appoint a substitute decision-maker who is 19 years or older to decide on appropriate treatment or health care for said person[478]. This directive comes into effect when the maker loses his or her capacity[479]. In the absence of a directive, the common law would prevail[480].

[474] Ibid.
[475] Advance Health Care Directives Act 1995 cA-4.1. Available at http://www.assembly.nl.ca/Legislation/sr/statutes/a04-1.htmAccessed on 14 April 2018.
[476] See Note 221.19-20.
[477] See Note 422. Section 3(1).
[478] Ibid. Section 3(2).
[479] Ibid. Section 4.
[480] Ibid. Section 5(4).

3.10.1. Formalities and Revocation of advance directives

The formalities for the directive is that it needs to be in writing, witnessed by two witnesses and signed by the maker[481]. Where the maker is unable to sign, it may be signed by another person in the presence and direction of the maker[482]. However, the person that signs cannot be the makers spouse nor the substitute decision-maker[483]. This Act clearly provides for the revocation of directives. As long as the patient is competent, the directive can be revoked by a later directive, a later writing signed by the maker declaring that they wish to revoke and by burning, tearing or otherwise destroying the directive[484].

3.10.2. Incompetent Patients

Part II deals with an incompetent person's health care. Where a healthcare professional has a patient that is incompetent, requires healthcare and cannot make a decision then such healthcare professional is entitled to firstly make a reasonable attempt in determining whether that patient has a substitute decision-maker who is available[485]. Secondly, if the substitute decision-maker is available then they must make a choice on behalf of the patient[486]. Important to note is that the healthcare professional does not require the substitute decision-makers consent in the case of an emergency[487].

Where a person requires treatment but has no competency to make decisions, has not made a directive while being competent, and has not appointed a substitute decision-maker, or a substitute decision-maker has been appointed

[481] Ibid. Section 6(1).
[482] Ibid. Section 6(2).
[483] Ibid. Section 6(2)(a).
[484] Ibid. Section 8(1)(a)-(c).
[485] Ibid. Section 9(1)(a).
[486] Ibid. Section 9(1)(b).
[487] Ibid. Section 9(2).

but refuses to act then the first named person if 19 years or older can act as a substitute decision-maker[488].

The substitute decision-maker has to always act in accordance with the directive and in accordance with the patient's wishes, values and instructions if they are incompetent[489]. Where the substitute decision-maker has no knowledge of the wishes or values then they have to act in the best interests of the maker[490]. If the court finds that the substitute decision-maker is acting against the wishes or values of the patient or in bad faith, it may suspend or terminate the appointment of that substitute decision-maker[491].

3.10.3. Protection from liability

No liability can be instituted to the substitute decision-maker if they have acted in good faith and in accordance with this Act[492]. If the healthcare professional makes a reasonable attempt to find the substitute decision-maker and subsequently, finds the incorrect substitute decision-maker then, the healthcare professional is not liable for failure to find the correct substitute decision-maker[493].

No action lies against a healthcare professional for complying with the substitute decision-makers decision to either administer or refrain from administering medical treatment to the patient if the healthcare professional has acted in good faith[494]. An interesting concept about this Act is that, it permits a person to give instructions in an advance directive as to the

[488] Ibid. Section 10(1). See Appendix B for the hierarchy of persons that can act as a substitute-decision maker.
[489]Ibid. Section 12 (1) (a)(b).
[490]Ibid. Section 12(1)(c).

[491] Ibid. Section 13.
[492] Ibid. Section 19(1).
[493] Ibid. Section 19(2).
[494] Ibid. section 19(3).

disposition of his or her body[495]. A person who wilfully conceals, cancels, damages, alters or forges an advance directive without the makers consent is guilty of an offence[496].

3.11. Case Law

3.11.1. Bentley v Maplewood Seniors Care Society[497]

In this case, a petition was brought by Mrs Bentley's family. The petition had applied for several orders but mainly, for the purpose that Mrs Bentley not be given any more nourishment or liquids as she had advanced Alzheimer's disease. The applicants claimed that Mrs Bentley whilst she was mentally capable in 1991 had written a living will stating that she did not want to be given any nourishment or liquids when her condition deteriorates[498]. She also stated in her living will that if there were no signs of recovery at all then she did not want to be kept alive by artificial means and she should be allowed to die[499]. In 2011, Mr Bentley found another document written by Mrs Bentley stating that she be allowed to die should a physical illness render her incapable of 'existing' however, she also stated that she would accept 'basic care' under such circumstances[500].

One of the issues before the court was whether this living will was written before or after the living will written in 1991. This confusion arose in the courts as the court did not know which of the two living wills represented her true wishes. Taking this into consideration, the court held that withdrawing food

[495] Ibid. Section 21(1).
[496] Ibid. Section 24.
[497] *Bentley v Maplewood Seniors Care Society* 2014 BCSC 165.
[498] *Bentley* supra (Par.5).
[499] Ibid.
[500] *Bentley* supra (Par.8).

and water from a person incapable of expressing their wishes and providing consent was neglect under the Adult Guardianship Act[501]. The court also held that, the fact that Mrs Bentley stated that she would accept 'basic care' under such circumstances meant that it would presumably include food and water. Thus, due to the fact that Mrs Bentley could not provide consent to being fed, the court held that the respondents could not withdraw nutrition and hydration from Mrs Bentley.

This case is an important case amongst Canadians because even though advance directives are permitted and legalized, it illustrates the fact that if an advance directive is not properly adhered to or not drafted in accordance with the requirements then it will not be legally binding and will not be upheld at no circumstances. This case portrays further that problems can and do arise if advance directives are ambiguous and vague.

3.12. Conclusion

This chapter has focused on the current legal position of advance directives in Canada. The position is much clearer as many provinces within Canada have enacted either legislation or policies allowing for its people to make directives. This in turn provides assurance to the people of Canada that their directives will be honoured and respected if they ever find themselves in an incompetent state and unable to make important treatment decisions[502]. Some of the policies and legislation includes and is not limited to the Personal Directives Act[503], The Healthcare Consent and Care Facility Admission Act[504], Advance Health Care Directives Act[505], The Ontario Mental Health Act[506], the Mental

[501] *Bentley* supra (Par.153).
[502] See Note 21.
[503] See Note 395.
[504] See Note 359.
[505] See Note 440.

Health Act[507], the Advance Care Planning Policy[508] and the Canadian Charter of Rights and Freedoms[509].

To have legal effect and recognition, advance directives have to be written in accordance with the requirements set forth by the above-mentioned Acts. If there is ambiguity or confusion then it gives rise to complicated situations which are difficult to solve. In the case of *Bentley*[510], even though her advance directive was drafted in accordance with the requirements, the fact that there was two conflicting directives lead to the court refusing to withdraw the artificial machinery keeping her alive.

The next chapter will focus on the current legal position of advance directives in the United Kingdom.

[506] See Note 346.
[507] *The Mental Health Act* of 1977.
[508] See Note 326.
[509] See Note 311.
[510] *Bentley* supra.

CHAPTER 4:

THE CURRENT LEGAL STATUS OF ADVANCE DIRECTIVES IN THE UNITED KINGDOM (UK)

THE CURRENT POSITION IN ENGLAND AND WALES:

4.1. Introduction

Amongst the UK individuals, 74% of individuals expressed interest in writing an advance directive because as they reasoned, their views would be known and their families and loved ones would be relieved of the pressure and burdens of having to make difficult treatment decisions for them[511]. Both men and women equally expressed this view[512]. When it came to physicians, 74 % of physicians declared that the decision was easier to make because patients had valid advance directives in place and that 92% of physicians found that, in most times, advance directives were being used by the elderly and aged people[513]. From a postal study questionnaire of 857 UK medical practitioners and comparison with data from other countries, the UK was found to be the highest country in which the concept of advance directives and end of life care decisions was openly discussed by physicians with colleagues, patients and relatives than in other countries[514].

[511] S Brauer, 'Country Reports On Advance Directives' (2008) 99 Available at https://www.google.co.za/url?sa=t&source=web&rct=j&url=https://www.ethik.uzh.ch/dam/jcr:00000000-14d5-886d-ffff-fffff1488f30/Country_Reports_AD.pdf&ved=2ahUKEwjp6vjpod7eAhUMDcAKHVtVDkYQFjAAegQIBhAB&usg=AOvVaw3aVle2fzol4bKblK22XRHT&cshid=1542555232372 Accessed on 30 October 2018.

[512] Ibid.

[513] Ibid.

[514] Ibid.

In England and Wales, advance directives are specifically governed by Statute. Namely, the Mental Capacity Act[515]. However, before the Mental Capacity Act[516] could come into effect, the English cases of *Bland*[517], *Re C*[518], *Re AK*[519], *Re T*[520], *Ms B v An NHS Hospital Trust*[521], *HE v A Hospital NHS Trust*[522] and *W Healthcare NHS Trust and Another v H and Another*[523], had arisen in the UK courts and had established that a valid refusal of treatment has the same legal authority as a contemporaneous refusal[524].

4.1.1. *Discussion of the case of Bland*[525]

In this case, the patient, Bland was seventeen (17) years old when he suffered from severe lung injuries in the Hillsborough football disaster. Due to these injuries, it eventually resulted in irreversible brain damage which left him in a permanent vegetative state. He remained in this state for over two years without any signs of recovery and was being kept alive by artificial means. The hospital authority together with Bland's family members sought an order to lawfully discontinue the life-sustaining machines and tubes keeping Bland alive so that he could die in peace and with dignity[526].

The issues in this case revolved around the notion of informed consent and incompetence. More specifically, what would the position be when a patient is

[515] The Mental Capacity Act of 2005.
[516] Ibid.
[517] *Airedale N.H.S. Trust v Bland* 1993 A.C. 789 (H.L.).
[518] *Re C (Adult: Refusal of Treatment) 1994 1 All ER 819 (QBD)*.
[519] *Re AK (2001) 1 FLR 1429*
[520] *Re T (Adult: Refusal of Treatment) 1992 4 All ER 649*
[521] *Ms B v An NHS Hospital Trust (2002) 2 All ER 449*
[522] *HE v A Hospital NHS Trust (2003) 2 FLR 408*
[523] *W Healthcare NHS Trust and Another v H and Another (2005) All ER (D) 94*
[524] *'Advance Decisions And Proxy Decision-Making In Medical Treatment And Research'* (2007) 3 Available at https://www.google.co.za/url?sa=t&source=web&rct=j&url=https://www.bma.org.uk/-/media/files/pdfs/practical%2520advice%2520at%2520work/ethics/advancestatements2007.pdf&ved=2ahUKEwi2qp7Zqd7eAhXCgVwKHZuHBIsQFjAAegQIAxAB&usg=AOvVawOGXDpYesi1xgKfDst5l5uQ Accessed on 30 October 2018.
[525] *Bland* supra
[526] Lawteacher '*Airedale NHS Trust v Bland*' (2013) Available from *https://www.lawteacher.net?vref=1* Accessed on 12 February 2018.

in a permanent vegetative state, cannot give their informed consent for treatment or cannot stipulate if they do not wish to be kept alive by artificial means and is rendered completely incompetent?[527]. The court found in favour of the hospital authorities, granted the order and held that they had the necessary approval to remove the tubes keeping Bland alive.

The case then went on appeal. The court held that the best method in determining whether to withdraw or withhold life-sustaining treatment of an incompetent patient was to be measured against the reasonable doctor standard[528]. In other words, whether a reasonable doctor would come to the same conclusion that the continuation of life-sustaining treatment would or would not be in the patient's best interests[529]. If the reasonable doctor came to the conclusion that the continuation would not be in the patient's best interests then, the doctor treating the patient was under no obligation or duty to continue with the treatment[530].

The House of Lords then compared Bland's condition to determine if the continued life-sustaining treatment was in his best interests and arrived at the conclusion that it was not[531]. They held that it was lawful to withhold the life-sustaining treatment keeping Bland alive[532]. In relation to advance directives, the court referred to a patient's autonomy in refusing life-sustaining treatment and the possibility of providing such an instruction in advance of incapacity[533]. The court held that, an advance refusal of treatment should "carry as much

[527] Ibid.
[528] See Note 4.84.
[529] Ibid.
[530] Ibid.85.
[531] Ibid.
[532] Ibid.
[533] Ibid.

weight as a refusal from a currently competent person".[534]Even though Mr Bland did not make an advance directive nor an advance decision regarding the refusal of life-sustaining treatment and was clearly not able to understand his condition or any treatment options available to him, the house of Lords used this case to consider a patient's rights to choose in relation to life-sustaining treatment and came to the conclusion that if a patient refuses treatment then it must be respected even if it results in death[535].

4.1.2. *Re C*[536]

C was a patient suffering from paranoid schizophrenia and during his confinement, he developed gangrene in his foot. If not amputated, he would die. However, C refused to consent to such amputation and acknowledged the fact that he would die as a result of not being amputated[537]. The issue before the court was whether C was competent and had the required capacity to make such a decision of not wanting his foot to be amputated.

The court in this case held that although the schizophrenia experienced by C affected his general capacity, he was still able to make valid decisions regarding his treatment[538]. The court held further that he understood and retained the relevant treatment information. Therefore, the court ruled that the amputation could not proceed without his consent nor could it be carried out without his consent in the future even if his mental capacity deteriorated[539]. This case is an example showing that advance directives are

[534] S Bonner '*Are Advance Directives Legally Binding or Simply The Starting Point For Discussion on Patient's Best Interests?* 2009 (339) *BMJ*1233.
[535] Ibid.
[536]*Re C supra*
[537] See Note 471.3.
[538] Ibid.
[539] Ibid.

not confined to end-of-life decisions but also involve the continuation of care[540].

4.1.3. *Re AK*[541]

In this case, the patient who was 19 years of age suffered from motor neurone disease and he had been on a ventilator. Without said ventilator, he would have died few months earlier. The only means of communication was through the movement of his eyes as he was able to answer 'yes' or 'no'. Using his eyes as communication, the patient asked the treating physicians to remove his ventilator and was fully aware at all times that this would result in his death[542].

The treating physicians then sought a declaration from the court that if they act in accordance with the patient's wishes and directive, that they would not be acting unlawfully[543]. The court held that in this specific case, where a physician is aware of a patient's wishes while he has made them whilst being of a sound and clear mind and still acts contrary to such wishes, then it will amount to being unlawful[544]. Since communication was so difficult and where the patient has clearly indicated his wishes shows that the patient has the said capacity to make the decision to remove the ventilator and the court granted and upheld his directive to remove the ventilator and to refuse treatment[545].

Though the cases of *Re C*[546] and *Re AK*[547] were decided prior to the enactment of the Mental Capacity Act[548], these decisions clearly show that the English

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[540] Ibid.
[541] *Re K supra*
[542] 'Re AK (Medical Treatment: Consent)' Available at *https://www.4pb.com/case-detail/re-ak-medical-treatment-consent/*Accessed on 29 October 2018.
[543] Ibid.
[544] Ibid.
[545] Ibid.
[546] *Re C supra*
[547] *Re AK supra*
[548] The Mental Capacity Act of 2005.

courts had the willingness to uphold valid and applicable advance care directives[549].

The following cases are examples of instances where the advance directives were not upheld and followed. Instead, the court had rejected said directives.

4.1.4. *Re T*[550]

This case involves a 20 year old woman ("T") who was 34 weeks pregnant when she was involved in an accident. After speaking to her mother who was a strict Jehovah's Witness, T informed the staff at the hospital that she did not want any blood transfusions although she was not a Jehovah's Witness herself[551]. A caesarean section was then carried out and the baby was born stillborn. At this point, she required a blood transfusion which would improve her state of health but the treating physicians could not provide her with same because of her advance refusal to receive any blood transfusions[552].

T's father and boyfriend applied to court to dismiss the advance directive. The court in this case upheld their request and ordered that the blood transfusion be given because her advance directive was not valid due to the fact that she was influenced by her mother in making one and it clearly did not reflect her true wishes[553].

[549] '*Law Reform Commission: Bioethics, Advance Care Directives*' (2009) Available at https://www.google.co.za/url?sa=t&source=web&rct=j&url=http://www.lawreform.ie/_fileupload/reports/rbioethics.pdf&ved=2ahUKEwjdou_7vd7eAhWKesAKHRJeAMkQFjAAegQIBRAB&usg=AOvVawOtP_G8j4wzD2A_ngof1yrW Accessed on 29 October 2018.
[550] *Re T supra*
[551] See Note 471.4.
[552] Ibid.
[553] Ibid.

4.1.5. Ms B v An NHS Hospital Trust[554]

In this case, the applicant was suffering from a disabling condition and in which she requested that her life support machine (a ventilator) be switched off. She had made an advance directive which clearly stated that she did not want to be kept alive by artificial means[555].

The issue before the court was whether she had the required capacity to do so because at first, she was found to have the necessary capacity but the treating physicians doubted her capacity[556]. She then applied to court to review the decision stating that she indeed had the requisite capacity when she made the living will and that treatment which was being provided to her was against her expressed wishes[557].

The court held that she had the necessary capacity and that the right to determine what shall be done with one's own body is a fundamental right within the society[558]. The court held further that patients with disabling conditions who are mentally competent has the same right to personal autonomy and to make decisions as any other person with mental competence and capacity[559].

4.1.6. *HE v A Hospital NHS Trust*[560]

This case dealt with a Muslim woman who later converted her faith to being a Jehovah Witness. She required life-saving blood transfusion and lost the capacity to make decisions consenting to treatment. Earlier, she had made an

[554] *Ms B v An NHS Hospital Trust supra*
[555] '*Ms B v An NHS Hospital Trust: FD 22 Mar 2002)* Available at: https://swarb.co.uk/ms-b-v-an-nhs-hospital-trust-fd-22-mar-2002/ Accessed on 29 October 2018.
[556] Ibid.
[557] Ibid.
[558] Ibid.
[559] Ibid.
[560] *HE v A Hospital NHS Trust supra*

advance directive refusing any kinds of blood transfusions under any circumstances.

However, her father argued that this advance directive should not be deemed as being valid because she was now engaged to a Muslim man and had consequently rejected her faith as a Jehovah Witness and as such, she had neither attended any of the Jehovah meetings[561]. Thus, her advance directive should not stand as her faith has changed drastically from the time she made her advance directive[562].

The court accepted the father's arguments and held that, "there are no formal requirements for a valid advance directive neither are there any formal requirements for a valid revocation of advance directive"[563]. All that is needed is that advance directives be updated to reflect the true wishes of the patient[564]. The court held further that where doubt exists as to the status of an advance directive, then physicians should always aim to preserve life and conduct the necessary blood transfusions[565].

4.1.7. *W Healthcare NHS Trust and Another v H and Another*[566]

In this case, a 59 year old woman had made advance statements previously years ago that she refuses any life supporting treatment or machines if she could not continue with a reasonable quality of life[567]. However, none of these statements made addressed the issues of artificial hydration and nutrition.

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[561] S, Woolley '*Jehovah's witnesses In The Emergency Department: What Are Their Rights*?' (2005) 10 (1136) *Emerg Med J* 870.
[562] Ibid.
[563] Ibid.
[564] Ibid.
[565] Ibid.
[566] *W Healthcare NHS Trust and Another v H and Another supra*
[567] *'W Healthcare NHS Trust v KH: CA 17 Sep 2004)* Available at: https://swarb.co.uk/w-helathcare-nhs-trust-v-kh-ca-17-sep-2004/ Accessed on 29 October 2018.

The court held that though her previously expressed wishes in that she does not want to be kept alive by life-support machines could be upheld, the fact that she made general statements regarding the quality of life and refusal of treatment was insufficient to amount to a valid and binding advance directive[568]. Therefore, she was not entitled to refuse the artificial feeding being provided to her[569].

4.2. Case Authority whereby a patient made an advance directive 'requesting' instead of 'refusing' artificial nutrition and hydration:

4.2.1. The Case of *Burke*[570]

Mr Burke (the patient) had a neurological condition and will eventually require artificial nutrition and hydration. He feared that upon losing the ability to communicate, physicians may withdraw said artificial hydration and nutrition[571]. He then sought judicial review on the guidance of withdrawal of artificial nutrition and hydration[572]. The High Court judge ruled that an advance directive requesting artificial hydration and nutrition would be regarded as being valid[573].

The Appeal Court then ruled that the patient was competent and that if he wished to receive artificial feeding and hydration in the given circumstance's, then removing it would be regarded as been unlawful[574]. The court held further that, when a competent patient indicates his wishes to remain alive via

[568] Ibid.
[569] Ibid.
[570] *R (Burke) v General Medical Council (2005) EWCA*
[571] '*Burke, Regina (On The Application Of) v General Medical Council and Others (Official Solicitor and Others Intervening) : CA 28 Jul 2005'*Available at: https://swarb.co.uk/burke-regina-on-the-application-of-v-general-medical-council-and-others-official-solicitor-and-others-interveing-ca-28-jul-2005/ Accessed on 29 October 2018.
[572] Ibid.
[573] Ibid.
[574] Ibid.

artificial means and any physician who knowingly discontinues treatment would be in breach of duty and guilty of murder[575].

The above mentioned common law principles were incorporated in the move towards the recognition and use of advance directives in the UK[576].The Law Commission for England and Wales proposed that advance refusals of treatment should have 'legal standing' under the law[577]. These developments eventually led to the passing of the Mental Health Act which came into effect on the 1st October 2007[578].

4.3. The Mental Capacity Act 2005[579]:

This Act enables individuals to write their own advance directive or to appoint a lasting power of attorney to make their views and preferences known in the event of them losing capacity[580]. However, important to note is that, these rights are limited to the refusal of specific medical treatments only[581].

Part 1, Section 24, Section 25 and Section 26 of the Mental Capacity Act[582] provides for the recognition and validity of advance directives. In whole, these sections entail that the maker must have the required capacity to refuse a specific treatment[583].

[575] Ibid.
[576] See Note 469.59.
[577] Ibid.17.
[578] Ibid.
[579][579] The Mental Capacity Act of 2005.
[580] See Note 471.1230.
[581] Ibid.
[582] The Mental Capacity Act of 2005.
[583] See Note 471.3.

4.3.1. What is meant by Capacity?

Capacity is defined as, "a person's capacity to make a particular decision at the time it needs to be made"[584]. It refers to an individual's ability to weigh up issues and arrive at a decision in relation to the type or specific choice that has to be made[585]. When these individuals possess such ability, they decide for themselves what they would like to happen to them in the future in the event of them no longer being able to make decisions[586].

The Act[587] states that a person lacks capacity if they are unable to understand information before them[588], if they are unable to retain that information long enough to make a decision[589], and if they are unable to communicate their decision[590]. However, effort should be made when deciding if a person lacks capacity to make a decision solely based on their inability to communicate[591]. As mentioned above, in the case of *Re AK*[592], communication was difficult for the patient as he could neither speak nor move and the only means of communication was via his eyes[593]. Using his eyes as communication, the patient asked the treating physicians to remove his ventilator. In this case, the court stated that since communication was so difficult and where the patient has clearly indicated his wishes shows that the patient has the said capacity to

[584] The Mental Capacity Act 2005, Code of Practice (2007) 3 Available at https://www.google.co.za/url?sa=t&source=web&rct=j&url=https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf&ved=2ahUKEwiJ8JnMz97eAhVklcAKHZvxDzoQFjANegQIARAB&usg=AOvVawOG220eMaCfiiKLxyPulcYn&cshid=1542567466723 Accessed on 30 October 2018.
[585] See Note 471.1.
[586] Ibid.
[587] The Mental Capacity Act of 2005.
[588] The Mental Capacity Act of 2005 Part 1, Section 3(1) (a)
[589] The Mental Capacity Act of 2005 Part 1, Section 3(1) (b)
[590] The Mental Capacity Act of 2005 Part 1, Section 3(1) (d)
[591] See Note 471.3.
[592] *Re K supra*
[593] See Note 489

make the decision to remove the ventilator[594]. Therefore, if a person lacks capacity, they are referred to as being incompetent to make a decision themselves[595].

4.3.2. Requirements for a valid advance directive:

The Act[596] states that the maker has to be over the age of 18. The Act[597] states further that, if the advance directive was made by an adult who is now incompetent and who issued the advance directive at a time when he/she was competent, it will be regarded as being valid[598]. It also states that the maker may withdraw or alter their advance directive at any time as long as they have the necessary capacity to do so and that, such withdrawal or alterations do not have to be in writing[599]. It can be made by simply telling another person about the change of mind[600]. Further, it states that, the advance directive will be binding if it has not been superseded by the appointment of a lasting power of attorney[601].

In summary, the main points of the aforementioned sections state that, the advance directive must be in writing, signed, witnessed and must include a clear written statement stating that it applies to the specific treatment even if life is at risk[602]. Secondly, it must be valid at the time it is put into effect. If there are any doubts or evidence to suggest that the maker has changed their mind then it will not be valid[603]. Thirdly, the advance directive must be applicable to the current circumstances at hand. If it does not specify the

[594] Ibid.
[595] See Note 471.3.
[596] The Mental Health Act of 2005.
[597] Ibid.
[598] See Note 471.4.
[599] Ibid.
[600] Ibid.
[601] See Note 458.99.
[602] Ibid.
[603] Ibid.

treatment that is now been proposed or if the circumstances have now changed, then said advance directive will not be valid and applicable[604]. Lastly, liability is excluded if the person at the time reasonably believes that the advance directive that is in existence is valid and applicable to the treatment[605].

4.3.3. Limitations on an individual's autonomy:

The Mental Health Act places some limitations on an individual with regards to their autonomy. The Act clearly states that individuals may not make an advance directive refusing basic care which is in relation to food, liquids, pain relief, hygiene measures and warmth[606]. An individual cannot request anything that is against the law. Neither can an individual make an advance directive refusing treatment for a mental disorder if they are to be detained under the Mental Health Act 1983[607].

4.3.4. Must physicians always abide by the advance directives made under the Act?

If advance directives are made under the Act and fulfil the requirements required by said Act, then it is regarded as being legally binding and physicians are to respect said directives if they are aware of it, if it is valid in all respects and if it applies to the current situation[608]. Physicians are bound regardless of the fact if they believe it is in the patients best interests or not[609].

[604] Ibid.
[605] Ibid.
[606] Ibid.98.
[607] Ibid.
[608] Ibid.97.
[609] Ibid.98.

4.3.4.1. What is meant by 'best interests"?

Both the ethical and legal rule is that mentally incapacitated people are treated in their 'best interests'[610]. When determining what is in a patient's best interest, the Mental Capacity Act[611] states that, the following factors are to be considered.

- The persons past and present wishes and feelings[612];
- Whether any written advance directives were made when they had the requisite capacity[613];
- The beliefs and values that would influence the decision to be made had they required the necessary capacity[614];
- Any other factors that are considered necessary in arriving at the decision[615];
- Whether any other person has been named that needs to be consulted on the matters in question[616];
- Any person that is engaged in caring for the person[617];
- Any person that has been appointed via a lasing power of attorney[618];
- And any deputy appointed for the person by a relevant court[619].

The Mental Capacity Act states further that, a person's age or appearance[620] or any aspects of his behaviour may not be considered solely on such a basis[621].

[610] See Note 271.2.
[611] Mental Capacity Act of 2005.
[612] The Mental Capacity Act of 2005 Part 1, Section (6) (a)
[613] The Mental Capacity Act of 2005 Part 1, Section (6) (a)
[614] The Mental Capacity Act of 2005 Part 1, Section (6) (b)
[615] The Mental Capacity Act of 2005 Part 1, Section (7) (a)
[616] The Mental Capacity Act of 2005 Part 1, Section (7) (b)
[617] The Mental Capacity Act of 2005 Part 1, Section (8) (a)
[618] The Mental Capacity Act of 2005 Part 1, Section (8) (b)
[619] The Mental Capacity Act of 2005 Part 1, Section (9)
[620] The Mental Capacity Act of 2005 Part 1, Section (4) (1) (a)
[621] The Mental Capacity Act of 2005 Part 1, Section (4) (1) (b)

4.4. Case Law

4.4.1. *W v M and Others*[622] (2011) EWHC 2443 (Fam)

One of the most recent cases under English Law in the UK was the case of *W v M and Others* (2011) EWHC 2443 (Fam)[623]. This case dealt with the patient ("M") who suffered brain damage. M's family sought an order from the court declaring that artificial feeding and hydration be withheld and withdrawn as M had previously expressed her wishes not to live a life whereby she would be dependent on others.

The court had to now decide before it whether M's previous statements made at the time she was competent amounted to a valid advance directive. In deciding this, the court sought to look at the common law which was further embedded in the Mental Capacity Act[624]. Under the common law and the Mental Capacity Act, an advance refusal of treatment must specifically refer to the scope of treatment as one of the requirements[625]. The court held that this requirement was not fulfilled and thus, the statements previously expressed could not be regarded as a valid advance directive[626]. There was also no evidence that the previously expressed wishes referred to the withdrawal of artificial hydration and feeding. The court dismissed the request brought forward by the family members of M[627].

[622] *W v M and Others (2011) EWHC 2443 (Fam)*

[623] Ibid.
[624] '*W v M and Others (2011) EWHC 2443 (Fam)*' Available at https://www.familylawweek.co.uk/site.aspx?i=ed86617 Accessed on 29 October 2018.
[625] Ibid.
[626] Ibid.
[627] Ibid.

4.4.2. *Mrs Brenda Grant case (2017)*[628]

Mrs Brenda had made an advance directive in which she clearly stated that she did not want to be artificially fed under certain circumstances. The reason she drafted an advance directive was due to the fact that she had watched her mother suffer as a result of dementia and felt strongly about not having her life prolonged[629].

When she suffered a stroke in 2012 in which she was unable to walk, talk or swallow, she was admitted to hospital. However, the hospital, misplaced her advance directive and since Mrs Brenda did not tell her family members or loved ones about her advance directive, she was kept alive by artificial means for 22 months by feeding tubes and a stomach peg[630]. In December 2017, the court ordered that Mrs Brenda's family receive £45,000 from the hospital as she received treatment against her valid wishes for 22 months[631].

It was argued that this case was a 'wake-up' call to both the hospital as well as every individual out there because hospitals need to ensure that they are treating patients in accordance with their current wishes[632]. They need to have systems in place that record patients advance directives or ensure that advance directives are placed on patient's charts before treating said patients. Individuals on the other hand need to ensure that they communicate about their advance directives to their physicians, General Practitioners, family or dear ones close to them[633]. They also can appoint power of attorneys so that

[628] *Brenda Grant (2017)*
[629] F Debney, 'living Wills and The case of Brenda Grant' (2017) Available at https://www.todayswillsandprobate.co.ik/guest-writers/living-wills-case-brenda-grant/ Accessed on 30 October 2018.
[630] Ibid.
[631] Ibid.
[632] Ibid.
[633] Ibid.

everyone is aware of the current wishes and preferences of the individual who has drafted the advance directive[634].

4.5. The Mental Capacity Act 2005, Code of Practice[635]

This Code supplements the Mental Capacity Act and provides guidance on how to deal with the said Act. The Code also has statutory force meaning that a legal duty exists upon individuals when they are dealing with adults who lack the required, necessary capacity to make treatment decisions for themselves[636]. There are sixteen chapters (16) in this code, all of which are dedicated to explaining the Mental Capacity Act in detail and how said Act should be interpreted and dealt with. It describes the Act, how the Act protects people that cannot make treatment decisions for themselves due to a lack of capacity, what is meant by the term 'best interests', how individuals may draft an advance directive the correct way so that it is upheld when they are no longer vested with capacity to act, the safeguards and the various ways to resolve disputes if they ever arise[637]. The Code consists of 301 pages all dedicated to the explanation of the Mental Capacity Act and is a code which is used to clarify ambiguity if ever it arises[638].

4.6. LEGAL POSITION OF ADVANCE DIRECTIVES IN IRELAND

In 2007, the Irish Council for Bioethics published an opinion on Advance Care Directives entitled, *Is It Time For Advance Healthcare Directives*?[639]. In this opinion, the Council stated that a lack of legislation makes the status of

[634] Ibid.
[635] See Note 531
[636] Ibid.4.
[637] Ibid.
[638] Ibid.
[639] See Note 496.

advance directives very unclear and that legislation needs to be drafted in order to implement the use of advance directives[640].

In the case of *The Ward of Court*[641], a 46 year old woman suffered severe brain damage and was being kept alive by artificial means. Her mother applied to court as to the proper care and treatment of her daughter. The main issue before the Irish court was whether it was permissible to withdraw the medical treatment of artificial hydration and nutrition[642].

The High Court and the Supreme Court followed the principles laid down in the case of *Bland*[643], that it would not be in the patient's best interests to continue the artificial feeding and that it should be withdrawn[644]. The High Court and the Supreme Court on appeal stated that such withdrawal was lawful.

In the Supreme Court, Judge O'Flaherty stated that, "consent to medical treatment is required in the case of a competent person...and, as a corollary, there is an absolute right in a competent person to refuse medical treatment even if it leads to death"[645]. Judge Denham stated that, "medical treatment may be refused for other than medical reasons, or reasons most citizens would regard as rational, but the person of full age and capacity may make the decision for their own reasons"[646].

Hence, as can be seen from the above statements made by the judges, it can be argued that, the judges indirectly refer to advance directives by stating that

[640] Ibid.
[641] *The Ward of Court Case 19962 IR 79*
[642] See Note 496.22.
[643] *Bland* supra
[644] See Note 496.22.
[645] Ibid. 23.
[646] Ibid.

patients have a right to refuse treatment even if it goes against medical advice[647].

4.7. *Re F (Mental Patient Sterilisation) 1990 2 AC 1*

Prior to the introduction of The Assisted Decision-Making (Capacity) Act[648], the legal status of proxy consent to treatment decisions was that no individual could consent or refuse medical treatment on behalf of another person who lacked capacity[649]. However, healthcare professionals could provide treatment without consent if it was deemed to be in the patient's best interest[650]. In the English case of *Re F (Mental Patient Sterilisation) 1990 2 AC 1*, the patient ("F") suffered from a mental disorder who had the mental age of a smaller child. She developed a sexual relationship with another patient and the treating physicians were of the opinion that she would not cope with pregnancy[651]. There was no other method of contraception and it was also not in the patients best interest to stop her from her relationship, that sterilisation would be the best option.

The patient's mother then sought a declaration declaring that such conduct would not be unlawful in sterilising the patient even though consent could not be provided by herself[652]. The House of Lords held that physicians could provide surgical as well as medical treatment to incompetent adults where such treatment was deemed to be in the best interests of said patient[653].

[647] Ibid.
[648] The Assisted Decision-Making (Capacity) Act of 2015.
[649] See Note 471.9.
[650] Ibid.
[651] Ibid.
[652] Ibid.
[653] Ibid.10.

4.8. The Assisted Decision-Making (Capacity) Act 2015:

The Assisted Decision-Making (Capacity) Act 2015 provides a statutory framework for individuals to make legally binding agreements to be assisted and supported in making important decisions where they lack the necessary capacity to do so[654]. Advance Healthcare directives were also introduced for the first time under this Act. The president has signed this Act on the 30 December 2015 but much of the Act still needs to be commenced meaning the Act still needs to be in force[655].

The Act provides for three types of decision-making supports. The first being, Assisted Decision-Making whereby an individual appoints another to assist in making a decision[656]. The ultimate decision is taken by the person himself/herself and not by the Decision-Making Assistant[657]. The second is Co-Decision Making whereby a person appoints another with whom they share a relationship of trust to jointly make a decision with them[658]. The third is the Decision-Making Representative, whereby the courts will make the necessary decision as the person lacks capacity to such an extent that the court will be required to step in[659].

The Act duly makes provision for enduring powers of attorney to act on a person's behalf if they lack the capacity to do so themselves[660].

Of utmost importance was the fact that, Advance Healthcare Directives was introduced for the first time under this Act in Ireland. The Act defines the

[654] 'Assisted Decision-Making (Capacity) Act 2015' (2016) 1 Available at https://www.google.co.za/url?sa=t&source=web&rct=j&url=http://www.citizensinformationboard.ie/downloads/relate/relate_2016_04.pdf&ved=2ahUKEwjSjKnjvePeAhWEjKQKHW64B38QFjACegQlABAB&usg=AOvVaw33eSMqvdhRke2h74rRdlFb&cshid=1542734530157 Accessed on 28 October 2018.
[655] Ibid.
[656] Ibid.2.
[657] Ibid.
[658] Ibid.2-3.
[659] Ibid.3-4.
[660] Ibid.5.

Advance Healthcare Directive as an advance expression made by a person having capacity at the time, expressing their preferences regarding their medical treatment decisions which may arise in the future and in the event of them losing their capacity to act[661]. The Act goes on further to state that, the advance healthcare Directive may be a standalone directive drafted by himself/herself or the maker could appoint a designated healthcare representative to exercise such powers under the Advance Directive[662].

Another important concept within this Act is that it mentions 'Refusals of Treatment' and states that specific refusals of treatment contained in advance healthcare directives is effective as if it were made at the time the maker had capacity[663]. A person over the age of 18 and who has the requisite capacity may refuse treatment for any reason even if it may result in their death[664].

The Act goes on to provide that, refusal of treatments contained in advanced healthcare directives will be valid provided that, the person lacks capacity at the time of treatment, the treatment is clearly and specifically identified in the Advance Healthcare Directive and lastly, the circumstances in which the refusal is to apply are clearly and specifically identified in the advance healthcare directive to someone else[665].

As mentioned above, prior to the introduction of The Assisted Decision-Making (Capacity) Act, the legal status of proxy consent to treatment decisions was that no individual could consent or refuse medical treatment on behalf of another person who lacked capacity[666].However, healthcare professionals could provide treatment without consent if it was deemed to be in the

[661] Ibid.6.
[662] Ibid.
[663] Ibid.
[664] Ibid.
[665] Ibid
[666] See Note 271.9.

patient's best interest[667]. This situation has been changed in the Act as the Act duly makes provision for enduring powers of attorney to act on a person's behalf if they lack the capacity to do so themselves[668].

To conclude, while this Act is yet to come into force, it is "nevertheless incumbent on all persons engaged in the care of persons with intellectual disabilities and mental health issues to be familiar with the ground breaking changes it will bring in this area of law"[669].

4.9. LEGAL POSITION OF ADVANCE DIRECTIVES IN SCOTLAND

Advance directives are not covered by Statute in Scotland nor have they been any specific cases which have been considered by the courts[670]. It is also stated that an advance directive is not legally binding in Scotland however, healthcare professionals must take into account the Adults with Incapacity (Scotland) Act[671] when deciding on treatment[672]. It is argued that an advance directive would be considered as binding in the event of it being clear, unambiguous and drafted with the required capacity to do so[673].

In the year 2002, Scotland introduced the Adults with Incapacity (Scotland) Act[674] to provide a statutory framework for the treatment of incapacitated people over the age of 16 years[675]. Though this Act[676] does not specifically cover advance directives and or advance decisions, it does oblige healthcare

[667] Ibid.
[668] See Note 601.6.
[669] See Note 496.20.
[670] See Note 471.3.
[671] Adults with Incapacity (Scotland) Act 2000.
[672] Ibid.
[673] Ibid.
[674] Adults with Incapacity (Scotland) Act 2000.
[675] See Note 471.3.
[676] Adults with Incapacity (Scotland) Act 2000.

professionals to take into account any past and present wishes made by them despite how they are communicated[677].

This Act[678] also makes provision for the appointment of health care proxies who should at all times be consulted unless an emergency situation arises[679]. The main groups of people that benefit under this Act[680] are, people with dementia, people with a learning disability, people with a severe sensory impairment and people with an acquired brain injury or severe and chronic mental illness[681]. This Act states that individuals over 16 with mental capacity have a legal right to refuse medical treatment[682].

4.10. The Mental Health (Care and Treatment) (Scotland) Act 2015

This Act[683] follows from The Mental Health (Care and Treatment) (Scotland) Act 2003 and mostly re-iterates the 2003 Act[684]. The Act 2015 requires Health Boards to place an advance statement or a document withdrawing an advance statement with the persons medical records and introduces a requirement for NHS Boards to keep a copy of any advance statement (or directive) received[685]. Another requirement of the Act 2015, is to provide certain information about the existence and location of the advance directive to the Mental Welfare Commission to be held on a register of information[686]. This 2015 Act also states

[677]See Note 471.4.
[678]Adults with Incapacity (Scotland) Act 2000.
[679] See Note 471.9.
[680]Adults with Incapacity (Scotland) Act 2000.
[681] See Note 471.9.
[682]Ibid.4.
[683] The Mental Health (Scotland) Act 2015.
[684]The Mental Health (Scotland) Act 2015.
[685] 'Mental Health (Scotland) Act 2015 – Key Provisions' Available at https://www2.gov.scot/Topics/Health/Services/Mental-Health/Law/2015Act-provisions Accessed on 29 October 2018.
[686] Ibid.

that where advance statements are not available, the patients known wishes should still be taken into account[687].

4.11. Conclusion

This chapter has focused on the current legal position of advance directives in the United Kingdom. As can be seen from above, the current legal position in England and Wales is clear in that, advance directives are specifically governed by Statute. Namely, the Mental Capacity Act[688]. Before the introduction of this Act[689], the English courts had already accepted valid refusals of treatments by competent patients showing that, advance directives were being accepted indirectly[690]. This lead up to the enactment of legislation to clarify the legal position.

In Scotland, there is no legislation or case authority to clarify the legal position of advance directives however, it is argued that, an advance directive would be considered as binding in the event of it being clear, unambiguous and drafted with the required capacity to do so[691]. The Adults with Incapacity (Scotland) Act[692] does not specifically cover advance directives and or advance decisions, but it does oblige healthcare professionals to take into account any past and present wishes made by them despite how they are communicated[693].

The next chapter will focus on the Conclusion and Recommendations that should be considered to clarify the legal position of advance directives in South Africa.

[687] Ibid.
[688] The Mental Capacity Act of 2005.
[689] The Mental Capacity Act of 2005.
[690] See Note 471.3.
[691] Ibid.
[692] Adults with Incapacity (Scotland) Act 2000.
[693] See Note 471.3.

CHAPTER 5

RECOMMENDATIONS AND CONCLUSIONS

5.1. Introduction

As already mentioned, South African Law has no clear legal guidelines or any definite statutes regarding advance directives[694] except for the Health Professions Council of South Africa Guidelines[695] and the South African Medical Association Guidelines[696]. The only draft legislation relating to advance directives in South Africa is the, South African Law Commission Report Project 86: 'Euthanasia and the Artificial Preservation of Life'[697]. However, the recommendations contained within this document have not yet been acted upon to date and Parliament has not passed any definite legislation to provide clarity. Ms Deidre Carter, a Member of Parliament has in addition, introduced the National Amendment Bill, 2018, (Private Member's Bill)[698] but this Bill has not yet been enacted as legislation amongst the Parliament. This Bill was introduced in order to clarify the legal position of Advance Directives by recognising advance directives, providing legal certainty and legal enforceability to said directives[699] to remove the uncertainty that exists amongst the topic of advance directives.

The main problem by Parliament not passing any definite legislation is that it leads to uncertainty about whether a medical practitioner complying with an

[694] See Note 4.938.
[695] See Note 5.
[696] See Note 6.
[697] See Note 11.
[698] See Note 12.
[699] Ibid.

individual's advance directive without a court order would be exposed to either civil or criminal liability[700].

5.2. Summary of the main findings

Firstly, a striking similarity between the three countries (South Africa, Canada and United Kingdom) is that they all entail the principle of informed consent[701]. All three countries follow the same principle in that they require the patients consent before any procedure or medical treatment can be administered or withdrawn. In South Africa, this principle is linked to the National Health Act[702] which re-affirms the principle and states that, the patient is to be provided with the range of procedures, benefits, risks and treatment options available[703].

Both Canada and the United Kingdom state that informed consent by a patient is vital and any physician failing to obtain such prior consent can be charged on the grounds of battery or negligence. In addition, all three countries follow the same common law principle in that, individuals have a right to refuse treatment.

Another similarity is that all three countries provide for the implementation of advance directives. Canada and the United Kingdom has legislation in place allowing a physician to respect the directive without being exposed to any civil or criminal liability if they have acted in good faith and without any negligence on their part. Though, Scotland is not specifically regulated by Statute and no case authority exists in favour of advance directives, it is argued that, advance directives would be regarded as been binding if they are clear, unambiguous

[700] See Note 4.938.
[701] Informed Consent means that, patients must be given sufficient information in a way that they can understand to enable them to exercise their right to make informed decisions about their healthcare.
[702] The National Health Act 61 of 2003.
[703] Ibid. Section 6(1) (a)-(d).

and was drafted with the required capacity to do so[704]. However, although South Africa has draft legislation and guidelines in place, the situation regarding such advance directives remains unclear[705]. There has only been a single case, *Clarke*[706] that mentioned advance directives but the court did not provide any guidelines on what the position ought to be. Therefore, the position moving forward remains very unclear and uncertainty exists amongst South Africans about whether or not their directive will be honoured. With the introduction of the Private Members Bill[707] introduced by Member of Parliament, Ms Deidre Carter, South Africans are hopeful that this bill will be passed and enacted as legislation because then would advance directives be considered as been legally binding and provide clarity in relation to advance directives[708].

When looking at the differences, England and Wales provide for individuals to validly refuse treatment[709]. In other words, individuals are not limited to making advance directives only with regards to end of life care decisions but also, to validly refuse treatment[710]. These wishes or advance statements are respected by the English courts as being valid advance directives.

5.5. Recommendations

Possible recommendations would include that in addition to the requirements put forth by the South African Law Reform Commission, that the following requirements be included:-

[704] See Note 471.4.
[705] See Note 4.938.
[706] *Clarke* supra.
[707] See Note 12.
[708] Ibid.
[709] See Note 458.
[710] See note 471.4.

5.5.1. That an advance directive made by a competent individual who is 18 years or older be recognised, valid, lawful as well as binding and upheld in South Africa.

5.5.2. That the treating physician complying with a valid refusal of treatment contained in a directive should be exempt from both civil and criminal liability in South Africa.

5.5.3. That the treating physician complying with a valid refusal of treatment by a delegate or substitute decision-maker or proxy should be exempt from both civil and criminal liability in South Africa.

5.5.4. This exemption from liability should also apply to delegate or substitute decision-makers or proxy/proxies acting in good faith.

5.5.5. No disciplinary actions for professional misconduct can be instituted against the treating physician complying with an advance directive.

5.5.6. That all requests made by individuals in an advance directive, who are 18 years or older be considered and duly followed[711].

5.5.7. That the National Amendment Bill, 2018, (Private Member's Bill) be enacted and passed as legislation amongst Parliament to allow for the legal recognition of advance directives.

5.6. Conclusion

When it comes to advance directives, South Africa has many gaps existing within the law that need to be bridged. Although we do not have a living will

[711] Kindly note that these recommendations are from the Author's point of view hence is not referenced.

statute in South Africa, the South African Living Will Society has a membership of more than 20 000[712].

By comparing the current legal position of advance directives to that of Canada and the United Kingdom, it can be clearly shown that South Africa is behind with law and is in dire need of Parliament passing definite legislation providing clarity for both healthcare professionals and for individuals who draft such advance directives to know where they and their advance directives stand in the future[713].

It has only been suggested by the Commission[714] that, physicians should respect living wills where there is clear evidence that it reflects the current wishes of the patient and was made when the patient was mentally competent but it does not mention the physician's liability and whether it is considered legal to respect and follow a directive or not[715]. As already recommended above, provisions clearly exempting a physician and substitute decision-makers from liability need to be included in the draft legislation. Provisions stating that advance directives are legal, valid and binding need to also be included.

Taking into account the rights[716] mentioned in the South African Constitution[717], one can argue that such rights promote the implementation and use of advance directives. The right to life[718] and the right to dignity[719] are the most important rights and the case of *Makwanyane*[720] stated that, the

[712] See Note 76.196.
[713] See Note 4.943.
[714] See Note 11.
[715] See Note 92.197.
[716] The Right to dignity, the Right to life, the Right to privacy and the Right to security and control over one's body.

[717] The Constitution Of the Republic Of South Africa, 1996.
[718] Ibid. Section 11.
[719] Ibid. Section 10.
[720] *Makwanyane* supra.

right to life must be a life worth living. Individuals who are terminally ill are in extreme pain and suffering and are rendered incompetent. Thus, where further treatment or procedures are futile, individuals should be allowed to die with dignity through upholding their prior wishes contained in their directives[721]. Section 12 of the Constitution[722] is also important as it contains provisions allowing individuals the right to refuse treatment.

The Biomedical Principles also promote the implementation and use of advance directives. It is argued that, a patients autonomy must be respected and upheld in South African Law as such directives were made by competent adults and were not unduly influenced, coerced or made such directives under duress[723]. Therefore, ethically the use of advance directives is justified[724].

This dissertation has focused largely on advance directives as it provided a clear definition of same. It has further illustrated the current legal position in South Africa and has compared as well as differentiated the said current legal position between other like –minded jurisdictions such as Canada and the UK as detailed above.

The patient's, family member's and physician's views was an important part of this dissertation in which each view was critically analysed in detail. Further, this dissertation has provided recommendations to improve as well as clarify the legal position of advance directives going forward as detailed in section 5.5. above.

[721] See Note 92.40.
[722] The Constitution Of the Republic Of South Africa, 1996.
[723] See Note 92.40.
[724] Ibid.

To conclude, advance directives should be made lawful and valid in South African Law to provide clarity eliminating any uncertainties that will continue to exist until such time as Parliament passes definite legislation.

APPENDIX A

HIERARCHY OF THE ACT

1. Guardian (e.g., court appointed) with authority to make such decisions.
2. Nearest relative (who, except in the case of a minor spouse, is 19 years of age or older).
3. Spouse.
4. Child.
5. Parent.
6. Person standing in loco parentis.
7. Sibling.
8. Grandparent.
9. Grandchild.
10. Aunt or uncle.
11. Niece or Nephew.
12. Other relative.
13. Public trustee[725].

[725] The Personal Directives Act (Chapter 8 of 2008), Sections 2(i) and Section 14.

APPENDIX B

HIERARCHY OF THE ACT

The following persons can act as the substitute-decision maker:-

(a) The incompetents person's spouse

(b) The incompetents person's children

(c) The incompetents person's parents

(d) The incompetents person's siblings

(e) The incompetents person's grandchildren

(f) The incompetents person's grandparents

(g) The incompetents person's uncles and aunts

(h) The incompetents person's nephews or nieces

(i) Another relative of the incompetent person and

(j) The incompetent's person's health care professional who is responsible for the proposed health care[726].

[726] Advance Health Care Directives Act 1995 cA-4.1. Section 10(1).

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